AN EFFECTIVE CLINICAL MODEL FOR DEALING WITH THE INEFFECTIVENESS OF AFRICAN AMERICAN CONGREGATIONS ADDRESSING MENTAL HEALTH

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ABSTRACT

AN EFFECTIVE CLINICAL MODEL FOR DEALING WITH THE INEFFECTIVENESS OF AFRICAN AMERICAN CONGREGATIONS ADDRESSING MENTAL HEALTH

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The context of the proposed project will be conducted at Hillside International Truth Center (Hillside) in Atlanta, GA. For Hillside to continue their mission of healing the "whole person," the church will need to examine this area of pastoral care and counseling. The hypothesis is that if clergy and congregations become culturally and competently educated and aware of their mental health then they can become more effective in helping, caring and serving others in the community. To accomplish this task, a clinical training and teaching model will be created. The methodology will be a mixed of qualitative and quantitative research.

ACKNOWLEDGEMENTS

The researcher acknowledges his mentor's Rev. Dr. Angela Washington and Rev. Dr. Donnell J. Moore for their wisdom, guidance and support in this doctoral experience. Our doctoral peer cohort group members for all their support: Kimberly Ridley, John Battle, Linda Johnson and Debra Manigault for helping to birth this ministry within me. Bishop Dr. Barbara L. King for her spiritual guidance, love, support and her encouragement. The Hillside International Truth Center family and the Barbara King School of Ministry for providing a place to do the ministry and for their support of my work of mental health. Dr. Kenneth L. Samuel for his spiritual leadership and support. The Victory for the World Church family for all their love and support. Dr. Marlo Mathis, Dr. Chad White, Dr. William Smith and Dr. Taunya Tinsley for all their guidance and encouragement. Rev. Sharon Thompson for her love and support.

DEDICATION

This research is dedicated to the researcher's mother, Etta Holmes Anderson and the researcher's aunt the late Earlene H. Burrell who nurtured and unconditionally loved this researcher with an everlasting love. This researcher also wants to dedicate this work to the his uncle, the late William "Bill" Holmes who saw the gift within and from an early age prophetically called this researcher professor and doctor.

INTRODUCTION

African Americans may be reluctant to discuss mental health issues and seek treatment because of the shame and stigma associated with such conditions. Many African Americans also have trouble recognizing the signs and symptoms of mental health conditions, leading to underestimating the effects and impact of mental health conditions. Community, religious and social stigmas around talking and dealing with mental health has contributed largely to the fact that many people experience shame, guilt and spiritual disconnection even in their religious community. Our community will never heal from the results of these stigmas around mental health if the community continues to be afraid to confront the stigmas, engage and have critical conversations about mental health awareness and wholeness.

There is a great need to have conversations around mental health in all spiritual and religious community. This research will approach mental health and wellness from a biblical, theological, theoretical and historical approach. This work will take a critical view and researched discussion of mental health in the African-American and create ways to help with mental health awareness.

The African American church and community is ineffective in dealing and understanding the importance of mental health. The hypothesis is that if clergy and congregations become culturally and competently educated and aware of their mental

health then they can become more effective in helping, caring and serving others. Mental health and wellness must be part of the spiritual development of the church.

Transformative and clinically learning intergraded with mental health and faith is a powerful transformative energy needed to bring about change in ourselves and then our community.

Chapter one consists of my ministry journey and focus that highlights the context and provides a synergy between the two. This chapter highlights my early experiences of unhealthy church leadership in which the leaders lacked mental health awareness and clinical training. This lack of mental health awareness and clinical training had a negative impact on my spiritual development. Mental health awareness and clinical training provides the foundation and the basis for spiritual freedom and liberation of the mind. Mental health awareness and wholeness is vital in the development of healthy congregations. A community and religious-based clinical pastoral care and counseling educational program will help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community.

Chapter two shows a biblical overview that many biblical characters suffered with mental health challenges such as seen in the lives of Job in the Old Testament and "Legion" in the New Testament. Both biblical passages speak to the ineffectiveness, the lack of concern and understanding of mental health as displayed by the reaction of the Job's community of friends and the Gerasene demoniac. The fact that many biblical characters had challenges with their mental health and experienced disruptive patterns and processes that affect their current life experiences and their relationship with God.

Chapter three shows a historical overview of mental health that mental illness has affected and disrupted the lives of many people and their life experiences. Mental health started in the Pre-Middle Ages as seen as persons with "spirits" or "special powers" such as shamans. Later, during the Greek and Roman periods mental illness was classified as being insane or madness as the goal was to keep persons from hurting themselves or others. The classical Greeks begin to use medicine and other "cures" to help those that were insane and curing the evil spirits. The early Christian church began the mission of caring for the sick and the poor and created places and missions for the mentally ill. Later, hospitals were established to help the mentally ill as they began to view the issue as a social problem. Dorothy Dix and others began work to help improve these asylums because the patients were treated unfair and many taken advantage of within these institutions.

Chapter four shows a theological overview that mental illness and health should be intergraded into the life and mission of the church. The mission of Jesus was to preach the good news to the poor and help bring healing to broken people. Theologian Amy Simpson shows that the role of the church is to minister to hurting people and those affected and effected by mental illness. She states that mental health is mainstream and that 25% of Americans eighteen or older suffer from a diagnosable mental disorder, one in four people. Simpson also states that fifty million people are affected by a mental disorder.[1] Upon examining the pastoral care and counseling perspective shows that as ministers, we are about the business of helping with "recovery of the soul."

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[1] Amy Simpson, *Troubled Minds: Mental Illness and the Church's Mission* (Downers Grove, IL: IVP Books, 2003).

Chapter five shows the theological foundations of practical theology, black liberation theology, black theology, process theology and psychology all show that theology is shaped by the mental lens, experiences and process that an individual or community views, two mainstream denominations, The United Church of Christ and The United Methodist Church. Using the discipline of psychology helps to inform us of the mind in dealing with mental health in the church. The pastoral psychology model helps us to be able to provide a clinical model for pastoral counseling and pastoral psychotherapy to help those who are hurting and affected by mental illness as well as honoring their faith beliefs and traditions. The clinical pastoral education model helps the minster and pastor experience contextual learning and self-reflection with the hope of helping them to see themselves and their brokenness and then helping others. The United Church of Christ and The United Methodist Church both have congregational models for pastoral care as well as mental health awareness within the walls of their churches.

Chapter six is the ministry focus project that uses a mixed model of quantitative and qualitative triangulation research that shows that there a dire need for clergy to be trained in mental health. This chapter also addresses the community and social media play in addressing the subject of mental health. This ministry project birthed a new understanding of the need for the integration of mental health and spirituality.

CHAPTER ONE

MINISTRY FOCUS

My ministry interest is the area of Pastoral Care and Counseling for the religious leadership and for congregations. I am interested in using a clinical pastoral training Clinical Pastoral Education (CPE) model integrated with a psychological and spiritual formation focus. This therapeutic clinical pastoral training model integrates a ministry reflection as seen traditionally in a CPE program incorporated in an individual clinical supervision/therapeutic model for ministry that is transformative. I am interested in developing a transformative pastoral care training model that is therapeutic and rooted and grounded in pastoral care and counseling for religious leadership.

The ministry context needs are a lack of clinical training for religious leadership. Secondly, there is a lack of education and understanding of mental health among clergy and congregations. Thirdly, religious leadership is not equipped and prepared to handle daily mental health and psychological needs of their congregations. My experience of working with spiritual leaders who are clinically trained or educated about mental health and pastoral care has brought me to this understanding of the needs for a therapeutic clinical training model that is transformative.

Transformational learning in a clinical content helps to provide the professional context needed for healing for self and then for the context. Using this transformative model for clinical pastoral training and pastoral care and counseling can be

transformative for the students as well and an effective model for transformation for the religious and spiritual communities. Out of these experiences, I learned that there is a major need for professional ministerial training, clinically and theologically. This lack of training caused my home church pastor to create an unhealthy church environment due the lack of understanding of effective ministry.

This process of transformation helps me work with myself as a human being and as a minister. In seminary, I first heard the call into pastoral care and also learned to start caring for myself. Professional therapy is important as it relates to being a professional minister. I began to seek professional counseling to work on my childhood issues of abandonment, rejection and emotional pain, which proved to be vitally important in my development. I was able to forgive my parents for their pain and hurt. I was able to work with all the church hurt and rejection. The transformational process of therapy helped me to gain a further understanding of myself as a primary source for helping others. The sense of true community at The Samuel D. Proctor School of Theology at Virginia Union University was very important as I began to build trusting relationship with other ministers, which provided healing.

I remember being in a church and ministry class at STVU. The professor discussed the brokenness of many clergypersons and African American ministers in particular. She described that we all need to be in therapy in order to heal from our brokenness. She also suggested that we should refer others in our congregations to get professional counseling. This message was my awakening moment to start on a journey of therapeutic work for myself. I began to discuss the pain and disappointments of my

parents, the pain and rejection from the church and also my unhealthy search for connection, love and belonging.

In my spiritual autobiography, there were experiences of emotional disconnection as seen in many churches between their congregants and their spiritual leaders. My mother was very much emotionally disconnected from being a mother. My mother was physically abused by my father and had to leave my father in fear of her life. My father was an alcoholic and very abusive verbally and physically toward my mother and other women. Most of my life, I have worked hard to make sure that a woman in my life was appreciated and supported. I never want to repeat the mistakes of my father.

My spiritual autobiography moves common themes of physical and emotional abandonment and spiritual rejection through experiences of integration of enduring hope and spiritual freedom. My spiritual journey begins from a story that my mother shared when I was still in my mother's womb. My mother described the fact that she was encouraged by a doctor to have an abortion due to her physical and domestic violence situation with my biological father and also the fact that my mother was not taking care of herself. My father had physically pushed my mother down the stairs while she was pregnant. The doctors then informed my mother that there was an 80% chance that I was going to be born with some other mental or emotional health challenge. My mother stated that God told her not to have an abortion and that she needed to move forward with her pregnancy until delivery. I was born with no mental or physical challenges.

Lebanon Baptist Church in Middlesex County, VA became my place of spiritual growth and maturity. I was actively involved in the youth choir, an active teacher of the Sunday school and president of the junior deacon's ministry. There I learned about

church leadership, spiritual abuse, manipulation and the rejection of woman in leadership. My pastor's wife was called into ministry early in the eighties and became our assistant pastor. There I observed and witnessed rejection of woman in ministry from the local community at times. However, I saw our assistant pastor showing great courage and standing strong in her faith and her calling from God. I observed my pastor "bleeding on the congregation," due to the many struggles in their marriage which were private and public struggles of ministry and how it affected their three children. I learned how to mask my pain and personal struggles in ministry. Hiding my pain and disappointments became a way of living as a young minister.

I was called into the ministry at the age of twelve years and did not understand all the aspects of ministry but knew deep within my soul, that God had called me. My views on the world, creation, love, mercy and God were different. The image of God for me was unconditional love toward all of us. This was not my experience in the church. I saw the church as place of "faking it until you make it," "wearing masks" and "hurt people hurting other people." There is the damaging model for ministries and followed by a hurt people hurting other people. Out of these experiences, I learned that there is a major need for professional ministerial training, clinically and theologically.

These experiences also caused me to take advantage of a training opportunity that was offered within our church at a young age. I did attend a local Bible school called Community Bible Institute while in high school, which was offered at my local church. This school was very important in helping me to develop as a minister.

There are three things that this school helped me understand which help to shape my understanding in ministry. First, this school taught me that there was more to the

Bible than what I was learning in my church. I was leaning that there is more to someone else's translated interpretation of the Bible. Secondly, this school helped me to understand that professional ministry begins with preparation and study. This school challenged my understanding of God and my understanding of myself. Thirdly, it taught me to be flexible in ministry. The community worship services were designed where we had two speakers, which were students and the order of service was prepared and graded on how you performed under pressure. The lesson learned was preparation and flexibility. This school also showed me to be my authentic self in ministry.

My professional development has been encouraging and has allowed me to make those connections with myself, which has greatly impacted my work in pastoral care and counseling. Clinical Pastoral Education (CPE) has been the catalyst for transformation and change for me personally and professionally. In my first unit of CPE, during the initial interview, the CPE supervisor challenged me by asking an important and life changing question: Your mother has her "demons," your father has his "demons" and you being a product of them, what are your "demons?" The question challenged me to admit that I too was dealing with demons and to identify processes to deal with my personal demons. This was one of the most challenging questions that I was ever asked. After that interview, I knew that I needed to further develop as a person, as a minister, as a chaplain and as a professional. From that point, I began to work with the homeless of downtown Atlanta at a church homeless and resource center.

In my first unit of CPE, I understood my connection as a minister in a different way. First, I understood and learned how to connect with other people in pain. Secondly, I learned how to be a clinically trained minister. Clinically training helps one discovery

the understanding of self, others, God and the world. "Clinical pastoral education and clinical supervisors help nurture supervisees by making meaning of situations through the lens of faith and from the broadest perspectives."[1] Many ministers are not trained to help persons make meaning of situations which broadens their faith.

The Clinical Pastoral Education process involves clinically training pastoral supervisors who "work with supervisees, pastoral supervisors stretch, challenge, and provide space for our supervisees to engage in thoughtful considerations……..{and} provide support for safe explorations of such considerations."[2] The Clinical pastoral education (CPE) process helps religious and spiritual leader in the development of nurturing relationships by providing a safe place where they can explore their own challenges, identify strengths and areas of growth as a minister. CPE is conducted under clinical supervision of a clinical supervisor and allows the participant to reflectively be a participant in their own learning.

Third, I learned how to use my pain, rejection and abandonment as a source in helping others. The wounded healer has serviced a major metaphor for helping others while I am still being healed, learning and growing.

> Perspective transformation is the process of becoming aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about the world; changing these structures of habitual expectation to make possible a more inclusive, discriminating and integrating perspective; and finally, making choices or otherwise acting upon these new understandings.[3]

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[1] Margaret Benefiel, *The Soul of Supervision: Integrating Practice and Theory* (New York, NY: Morehouse Publishing, 2010), 52.

[2] Benefiel, *The Soul of Supervision,* 52.

[3] Benefiel, *The Soul of Supervision*, 27.

Fourth, I learned the power of learning clinically and how to use ministry reflection as a way to grow spiritually, professionally and spiritually. Clinical supervision was the tool that changed my way of thinking, learning and being. "Transformative learning may be defined as learning that transforms problematic frames of reference to make them more inclusive, discriminating, and reflective, open, and emotionally able to change."[4] "Learning occurs in one of the four ways: by elaborating meaning schemes, schemes, transforming meaning schemes, and transforming meaning perspectives."[5]

My clinical training continued as a year CPE residency at Emory University through The Emory Center for Pastoral Education in Atlanta, GA. There, I furthered my clinical training as a clinical trained chaplain and learned the understanding of how to minister from a deeper connection under supervision of group and individual supervision. This experience opened my hunger for a therapeutic and spiritual understanding for clinical training for ministers. Clinical education has taught me to be creative in the thinking theologically. In others words, this is a vital purpose of clinical pastoral training to help the trainee to think critically and theologically in helping others as they connect to their own spiritual and emotional experiences.

My professional experiences show that the minister has to be ministered to, first, in order to effective help and support others. The transformation is a transformation or an awakening of one's self and identity as a minister within his or her self, first, then can transfer to helping others once they are in touch with their own pain and brokenness.

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[4] Jack Mezirow and Edward W. Taylor, *Transformative Learning in Practice: Insights from Community, Workplace, and Higher Education* (San Francisco, CA: John Wesley and Sons, 2009), 71.

[5] Mezirow and Taylor, *Transformative Learning in Practice*, 22.

My ministry has evolved into providing a transformational education and spiritual learning center. The main focus is the exploration of the mind, body and Spirit. This place of transformation is a spiritual, mental and emotional transformation of the "Soul" which incorporates usage of clinical education and training, an expansion of spirituality using psychological theories of mindfulness, cognitive and existential theories. Critical thinking skills and an expansion of knowledge and understanding which comes from a metaphysic and exploration of one's self and one's self in ministry.

My professional development and theology of inclusion has expanded over time. I began first by understanding that authentic ministry begins with myself and then expands to others. I must see myself in other people. Secondly, being at these two churches taught me to begin to further think independently about God, myself and others. Thirdly, these two churches helped me to accept other people different than myself regardless of race, class, culture, creed or sexual orientation. A theology of inclusivity and acceptance began for myself and others as I began to grow and expand in consciousness of God.

> Addiction to abusive religion can destroy your self-esteem, sap your energy, undermine your personal goals and career aspirations, undercut your relationships, make you physically and mentally sick, and leave you gasping for more religion than ever. With this historical context, the importance of religion clearly stems from one simple truth: its potent influence makes it a tool to get what we want: money power and a sense of superiority, even the suppression of views. Religion saturates our culture and invades our politics, influences business and reaches into every school and artistic inspiration. It has exploded beyond the walls of the church.[6]

As I began my first unit of CPE, there I understood the connection as a minister in a whole different way. First, I understood and learned how to connect with other people in

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[6] Carlton Pearson, *Gospel of Inclusion: Reclaiming Beyond Religious Fundamentalism to the True Love of God and Self* (New York, NY: Simon and Schuster, 2006), 61.

pain. Secondly, I learned how to be a clinically trained minister. Clinically training helps one discovery the understanding of self, others, God and the world.

"Clinical pastoral education and clinical supervisors help nurture supervisees by making meaning of situations through the lens of faith and from the broadest perspectives." Pastoral supervisors "work with supervisees, pastoral supervisors stretch, challenge, and provide space for our supervisees to engage in thoughtful considerations. We provide the support for safe explorations of such considerations. And it is though such nurture that we help to shape and prepare those under our leadership to become meaning-making, faithfully acting leaders themselves."[7]

Third, I learned how to use my own pain, rejection and abandonment as a source in helping others. The wounded healer has serviced a major metaphor for helping others while I am still being healed, learning and growing. "Perspective transformation is the process of becoming aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about the world; changing these structures of habitual expectation to make possible a more inclusive, discriminating and integrating perspective; and finally, making choices or otherwise acting upon these new understandings."[8]

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[7] Benefiel, *The Soul of Supervision*, 52.

[8] Benefiel, *The Soul of Supervision*, 27.

make them more inclusive, discriminating, and reflective, open, and emotionally able to change."[9] "Learning occurs in one of the four ways: by elaborating meaning schemes, schemes, transforming meaning schemes, and transforming meaning perspectives."[10]

As we are transforming our meaning we must understand that our faith is universal and every experience affects our mental understanding of ourselves, God and the world. James Fowler stated, "I believe faith is a human universal. We are endowed at birth with nascent capacities for faith. How these capacities are activated and grow depends on to a large extent on how we are welcome into the world and what kinds of environments we grow in.[11] Our faith development has a lot to do with how our beliefs systems are shaped. Our religious contexts and experiences impacts our cognitive learning, therefore how the religious community deals with mental health affects our capacity to grow and learn spiritually. Mental health and faith requires interaction and requires a nurturing environment. Therefore, transformative and clinically learning intergraded with mental health and faith is a powerful transformative energy needed to bring about change in ourselves and then our community

Develop the Synergy

A community and religious-based clinical pastoral care and counseling educational program will help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community. This program will address

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[9] Mezirow and Taylor, *Transformative Learning in Practice*, 71.

[10] Mezirow and Taylor, *Transformative Learning in Practice*, 22.

[11] James W. Fowler, *Stages of Faith: The Psychology of Human Development and The Quest for Meaning* (New York, NY: Viking Press, 1995), xiii.

the following community issues and deficiencies of lay leaders and clergy for effective transformational learning within their religious context.

> The future of pastoral supervision seems to be dependent on three concepts if it to remain relevant in today's and tomorrow's world: transformational/adult learning as a central educational theory, cultural bridging as a central component of personality theory, and liberation as a central theological construct within the supervisory alliance.[12]

The Joshua Generation has a community partnership with Hillside International Truth Center is providing affordable mental health services to the congregants of Hillside, the Hillside community and the surrounding areas of metro Atlanta. The Joshua Generation and its entities are vital in fulfilling the mission of the Hillside's mental health outreach.

The Joshua Generation Care and Consultant Services, LLC currently serves over 200 individuals families and couples and groups in the metro Atlanta area. The organization provides mental health services but the main focus is spirituality and therapeutic services to be able to educate them and to help people explore the inner parts of spirituality and growth.

The Joshua Generation Enterprises consists of three current entities including support of a 501c3 organization. All three entities promote and provide the following to the community and our nation by:

1. Developing, nurturing, empowering and coordinating a nationwide network of mental health services to strengthen and educate those coping with mental health issues and other life's problems.

2. Providing, educating and partnering with supportive community mental health and spiritual services to promote knowledge and wellness in the community.

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[12] Teresa Snorton, *Courageous Conversations: The Teaching and Learning of Pastoral Supervision* (New York, NY: University Press of America, Inc., 2010), 122.

> 3. Educating and empowering the people of Georgia and the nation about mental health and spirituality through educational and training programs in order to improve the quality of life for others.[13]

The ministry context faces several issues found within the community and within the organization. First, there seems to be a lack of education around the mission of pastoral care professionals. The stigmas associated with mental diagnosis, medication management and other stereotypes hinder person from receiving the proper medical health diagnosis and medical care needed for effective change.

Secondly, lack of interest and openness to mental health from the religious or spiritual community. There seems to be a resistance from many spiritual and religious leaders around issues of mental health and pastoral care. Many religious leaders are most likely to promote prayer and other rituals over referring someone to a qualified and trained mental health professionals.

President Theodore Roosevelt's speech in Paris, France on April 23, 1910 and quoted in Brene Brown's book, *Daring Greatly*:

> It is not the critic who counts; not the man who points out how the strong stumbles, or the doer of deeds could have done better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly' who errs, who comes short again and again. ....because there is no effect without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotion; who spends himself in a worthy cause;...who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly [14]

There are several words that reflect my spiritual autobiography found in this quote. "Who at the best knows in the end the triumph of achievement," and at least fails while daring

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[13] The Foundation for Therapeutic and Spiritual Empowerment, Inc., bylaws, 2013.

[14] Brene Brown, *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent and Lead* (New York, NY: Penguin Random House, 2012), 1-3.

greatly." Daring greatly is the theme of my life. Daring and looking for love, belonging and connection. Learning that love, belonging can only be reached by daring greatly to love, daring greatly to belong, daring greatly to connect and daring greatly to exist. Yes, the courage to exist. The courage was established to be myself, spiritually and to know that I am complete, whole and was created in the image of God. Making those connections have helped me to survive life, spiritually and emotionally. "Love and belonging are irreducible needs of all men, women and children. We're hardwired for connection-it's what gives purpose and meaning to our lives."[15] It takes great courage to be an effective leader in today's world and more courage to effectively lead a congregation.

Thirdly, many religious and spiritual leaders need mental health counseling to help deal with the challenges and struggles of leadership in the twenty-first century religious community. This lack of training, education and ignorance of mental health leads many religious and faith leaders to have substance or sexual abuse, broken and unhealthy relationships, ministry burnout and even suicidal ideation or suicide for many religious and spiritual leaders.

Fourthly, the lack of trained professionals in mental health or pastoral care and counseling causes a shortage to person receiving mental health services especially in urban and rural communities. Many African American communities are greatly affected by the shortage of trained professional that can relate to the struggles that they are facing.

My proposal is that we would provide ministries and ministry models that are rooted and grounded in pastoral care and counseling and have clinically trained religious

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[15] Brown, *Daring Greatly,* 1-3.

and spiritual leaders that are involved and connected to the life and life experiences of their congregations and communities. This transformational model through clinical training provides a safe and effective context for the minister to explore their own hurts, fears and pain, which helps them to then be able to effectively ministry and support others that are in pain.

The main question is: what type of ministry are we doing if our ministry leaders are not trained to deal with the current issues that many of our congregations are dealing with? Congregants and the community bring their self-hatred, trauma, pain, emotions, dual diagnosis, depression, hurts, fears etc. How are we providing effective pastoral care to our congregations and community? If effective ministers are not equipped to handle the traumatic experiences of their congregation Spiritual abuse is one of the results of the lack of training and education.

Secondly, lack of a transformational and clinical model for ministry lead to ineffective ministry. "Theological reflection is a creative process."[16] Theological analysis and theological construction are primary functional parts of understanding "the creative deliberative theological reflection, and in practice are interrelated and carried out together."[17] In others words, this is a vital purpose of clinical pastoral training to help the trainee to think critically and theologically in helping others as they connect to their own spiritual and emotional experiences.

Thirdly, lack of a transformational and clinical model for ministry leads to a lack of appreciation for authentic ministry. One main concern is the effective practice of

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[16] Howard Stone and James Duke, *How to Think Theologically* (Nashville, TN: Augsburg Fortress, 2013), 63.

[17] Stone and Duke, *How to Think Theologically*, 63.

ministry. If the religious lay ministers and clergy are not performing effective ministry, what type of ministry models are we using and how effective are the model. The 2005 Standards of the Association of Clinical Pastoral Education, Inc., is indicative of the field's struggle to continue to define pastoral supervision as the integration of self (skill/identity) with the practice of ministry in a changing world with diverse spiritual markers and reference points.[18]

Secondly many religious leaders lack the clinical knowledge or understanding of any personality or any theoretical model for dealing effectively with persons. "The future of effective clinical pastoral education involves the subtle but critical shift from adult learning theory directed toward insight and awareness to one directed toward transformation."[19] Insight oriented and self-awareness integrated in ministry reflection and pastoral supervision will help the clinical pastoral educational students gain a better sense of themselves in order to effectively minister to others. Transformational learning moves us away from a theology of "Snakeology" in the words of Dr. John Kinney, Dean, at the Samuel D. Proctor School of Theology at Virginia Union University to a reclaiming our divine nature of our truth being one with God and understanding the transformative power within all of men and woman.

Using this transformative model for clinical pastoral training and pastoral care and counseling can be transformative for the students as well and an effective model for transformation for the religious and spiritual communities. Transformational learning in a clinical content helps to provide the professional context needed for healing for self and

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[18] Snorton, *Courageous Conversations*, 119.

[19] Snorton, *Courageous Conversations*, 123.

then for the context. Thirdly, there is a lack of qualified clinical trained religious leaders able to provide effective ministry to the congregation and community that they serve. This educational model will help train and educate religious leaders to help prepare them for effective ministry.

The future viability of pastoral supervision relates to the personality theory embedded within any specific supervisory practice.[20]

> In developing supervisory competence and the ability to supervise effectively, the following goals are non-negotiable. Supervisors must be able to: 1) understand the self and others as cultural living human documents, 2) articulate a theory, theory of personality, education and group theory that reflects an understands of one's own culture and the culture of others, 3) develop the ability to supervise students individually and in groups with an awareness of the cultural dynamics that are operative, and 4) develop a CPE curriculum that reflects the cultural diversity of the institution or facility and the community.[21]

I am interested in learning the following objectives for my ministry project.

First, I will be developing, nurturing, empowering and coordinating a community-based clinical pastoral care and counseling educational program that will help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community. Secondly, I will be analyzing and promoting clinical knowledge, psychological understanding, spiritual wellness and theoretical approach in the community to help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community. Thirdly, I will be educating and empowering the religious students to make transformational learning to help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community.

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[20] Snorton, *Courageous Conversations*, 123.

[21] Snorton, *Courageous Conversations*, 125.

> Clinical pastoral education and clinical supervisors help nurture supervisees by making meaning of situations through the lens of faith and from the broadest perspectives." "Pastoral supervisors "work with supervisees, pastoral supervisors stretch, challenge, and provide space for our supervisees to engage in thoughtful considerations. We provide the support for safe explorations of such considerations. And it is though such nurture that we help to shape and prepare those under our leadership to become meaning-making, faithfully acting leaders themselves.[22]

Conclusion

A community-based clinical pastoral care and counseling educational program will help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community. This program will address the following community issues and deficiencies of lay leaders and clergy for effective transformational learning within their religious context.

This community-based program must involve supervision that helps students to: 1) understand the self and others as cultural living human documents, 2) articulate a theory, theory of personality, education and group theory that reflects an understands of one's own culture and the culture of others, 3) develop the ability to supervise students individually and in groups with an awareness of the cultural dynamics that are operative, and 4) develop a CPE curriculum that reflects the cultural diversity of the institution or facility and the community.[23]

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[22] Benefiel, *The Soul of Supervision*, 52.

[23] Benefiel, *The Soul of Supervision*, 125.

CHAPTER TWO

BIBLICAL FOUNDATIONS

This chapter will highlight an Old and New Testament scripture: Job the third chapter and Mark the fifth chapter, which serves as the foundational text for the doctoral project. Given the misunderstanding of mental health and illness, it is important to first develop a working definition of mental health and illness. Secondly, the discussion will continue from a biblical perspective, mental health and its impact on the ancient society in terms of biblical suffering and its importance. Thirdly, the pericope of Job and Mark will be examined exegetically through its historical, literary and impact on the community as seen in those biblical texts. In conclusion, the study of these two chapter will reflect on the correlation to the foundation of the study of mental and illness in our modern society.

Mental health and illness is a very important part of understanding the biblical narratives, situations and condition within the biblical text. Mental health is addressed in both the New and Old Testament. Mental health and illness determines the foundation for the church and the community because it plays a pivotal role in behavior and cultural norms within the ancient society. Mental health challenges greatly affected their behavior, decisions and choices as members of their community and relationship to God.

The *Dictionary of Pastoral Care and Counseling* defines mental health:

> As a condition of well-being in relation to self and others characterized by such qualities as (a) positive self-acceptance, (b) accurate perception of others and the world. (c) stability and appropriateness in mood, (d) balance and purposiveness in behavior, (e) dependable sense of identity and values, (f) adaptability to one's environment, (g) ability to engage in productive work and fulfilling love, and (h) commitment to a source of devotion beyond oneself.[1]

Mental health as it relates to illness is referred to the variety of enduring or recurring mental disturbances in pattern of an individual's thinking, mood or behavior that is typically associated with painful distressful and or impairment of social, occasional or leisure functioning.

The National Alliance on Mental Illness (NAMI) defines mental illness as a "mental conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning" and "often result in a diminished capacity for coping with the ordinary demands of life."[2] A working definition for mental health and illness that will be referred to throughout the chapter is that mental health and illness is any life condition (emotional, psychologically or spiritual) that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning which diminishes one's capacity for coping with the ordinary demands of life and disrupts our social or spiritual connection that God wants us to enjoy.

> In psychology, mental illness is defined as a disorder of the brain resulting in the disruption of a person's thoughts, feelings, moods, and ability to relate to others that is severe enough to require psychological or psychiatric intervention. While many people will have significant changes in their thoughts, emotions, and relationships during a normal lifetime, the changes usually are not severe enough to require treatment. A mental illness, on the other hand, is a debilitating

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[1] C. S. Aist, *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abington Press, 2005), 711.

[2] Amy Simpson, *Troubled Minds: Mental Illness and the Church's Mission* (Downers Grove, IL: IVP Books, 2003), 34.

> experience in which the person is simply unable to function normally over an extended period.[3]

The working definition and focus will be used through this document in discussing mental health and mental illness.

Mental Health and Illness in the Bible

> In examining the lives of most biblical characters and their life experiences we see that most biblical characters faced challenges with their mental health. What we call mental illness has not historically always been treated as a medical problem. In the not-too-distant past, the abnormal thoughts, feelings, and behaviors often associated with these disorders were thought to be signs of personal weakness and something to be ashamed. Unfortunately, there is still a far-too-common perception in the church today, resulting in the alienation of thousand who desperately need the spiritual support that only the body of Christ can provide.[4]

Many people believe that mental illness does not exist in biblical times and it just a "modern invention to legitimize sinful behavior."[5] The biblical account of madness and insanity are used to "describe a set of thoughts and behaviors recognized to be extreme, debilitating, and abnormal."[6]

Biblically ignorance of mental health can be a major challenge in looking at the lives of the characters in the Bible:

> Individuals displaying abnormal thoughts and behaviors- the mentally ill- were clearly known throughout biblical history. Today those same abnormal thoughts and behaviors have been categorized into a set of specific mental disorders for which many effective interventions and treatments have been developed. Mental health research and practice have made significant strides in relieving the mental and physical suffering of those afflicted with mental illness. Yet there continues

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[3] Matthew S. Stanford, *Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness* (Downers Grove, IL: InterVarsity Press, 2008), 43-44.

[4] Stanford, *Grace for the Afflicted*, 43-44.

[5] Stanford, *Grace for the Afflicted*, 46.

[6] Stanford, *Grace for the Afflicted*, 46.

> to be a high level of suspicion, distrust, and even fear in the church when it comes to psychology and psychiatry. The simple fact is that Christians develop mental illness at the same rates seen in the general population, and admonitions such as "You need to pray more" or "This is just the result of a lack of faith" are ineffective in dealing with the problem.[7]

The biblical narrative contains many accounts of the lives of people that faced life conditions (emotional, psychologically or spiritual) that disrupted their thinking, feeling, mood, ability to relate to others coping with the ordinary demands of life and their relationship with God. Life disruptions expressed themselves in situations of suffering, pain, mental or emotional anguish, depression or grief etc.

The Old Testament speaks of mental health as Job experienced great suffering, loss, grief and pain. Job's life experience of loss caused a mental disruption that caused Job to curse the day of his birth (Job 3). Job was also challenged by his community of friends as he dealt with economic, physical and emotional devastation. This section will show how Job experienced his life disruption, which hindered his capacity to cope with the normal daily activities, questioning his faith and his connection to God.

The New Testament speaks of mental health as the man identified by his condition named Legion experienced a mental disruption that caused this man to be disconnected to his community, live in the tombs, cut himself with stones and consistently cry for help (Mark 5:1-20). This section will show that this man's life disruption was a result of mental illness that hindered his capacity to cope witb normal daily activities, his faith and connection to God.

The Bible shows biblical accounts in which mental health was experienced in terms of suffering, grief and loss and how the community experienced a person with

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[7] Stanford, *Grace for the Afflicted*, 46.

mental health challenges that disrupted their connection with God, others and the community. These challenges hindered these two individuals from functioning as people being "created in the image of God" and "fearfully and wonderfully made" by God. In examining the life disruptions (emotionally, physically, socially, spiritually and psychologically) it is important to also address the ways in which the community responded to their life challenges.

Old Testament

The Old Testament scripture is Job 3: 1-26 and it states:

> After this Job opened his mouth and cursed the day of his birth. Job said: "Let the day perish in which I was born, and the night that said, 'A man-child is conceived.' Let that day be darkness! May God above not seek it, or light shine on it. Let gloom and deep darkness claim it. Let clouds settle upon it; let the blackness of the day terrify it. That night—let thick darkness seize it! let it not rejoice among the days of the year; let it not come into the number of the months. Yes, let that night be barren; let no joyful cry be heard in it. Let those curse it who curse the Sea, those who are skilled to rouse up Leviathan. Let the stars of its dawn be dark; let it hope for light, but have none; may it not see the eyelids of the morning—because it did not shut the doors of my mother's womb, and hide trouble from my eyes. "Why did I not die at birth, come forth from the womb and expire? Why were there knees to receive me, or breasts for me to suck? Now I would be lying down and quiet; I would be asleep; then I would be at rest with kings and counselors of the earth who rebuild ruins for themselves, or with princes who have gold, who fill their houses with silver. Or why was I not buried like a stillborn child, like an infant that never sees the light? There the wicked cease from troubling, and there the weary are at rest. There the prisoners are at ease together; they do not hear the voice of the taskmaster. The small and the great are there, and the slaves are free from their masters. "Why is light given to one in misery, and life to the bitter in soul, who long for death, but it does not come, and dig for it more than for hidden treasures; who rejoice exceedingly, and are glad when they find the grave? Why is light given to one who cannot see the way, whom God has fenced in? For my sighing comes like my bread, and my groaning's are poured out like water. Truly the thing that I fear comes upon me, and what I dread befalls me. I am not at ease, nor am I quiet; I have no rest; but trouble comes.[8]

[8] Biblical citations within this document are from the New Revised Standard Version unless stated otherwise.

Many biblical scholars have noted that the experience of Job and after his long silence showed signs of mental breakdown and perhaps a form of depression which many people experience after a tragic loss. Newsom describes Job 3:1-2 as the following:

> Chapter 3 begins with two introductory sentences, one in the style of the prose tale (v.1), the other in the style of the dialogue that follows (v. 2). The opening phase ("after this") establishes continuity with the seven days and seven nights of silence during which Job's friends sat with him. The period of silence occupies the narrative place if the third test of Job. Just as the other two tests hinged on whether Job would "curse God," so also here Job's speech is critical, solemnly introduced by the statement, "he opened his mouth." According to the conventions of traditional storytelling, which often patterns of three, the third repetition should provide heightened tension and definitive resolution. Just at the critical moment, the narrator says he opened his mouth and cursed. The word is not the euphemistic "blessed" but the word it has masked is chaps. 1-2, "cursed". Only with the last word of the sentence does the narrator apparently resolve the tension: "he opened his mouth and cursed his day" (i.e. the day of his birth; see v3). What does it signify to curse the day of one's birth? In antiquity curses and blessings were understand as acts that had a real effect under proper conditions. Although some interpretations assume that Job was attempting an effective curse, others references in the Bible to cursing the day of one's birth suggest that is it a rhetorical gesture. Most obviously, it highly charged way of expressing the wish that one had never been born. The curse takes the energy of self-directed aggression and transfers it to an external object, the day of one's birth.[9]

Cursing the day of one's death and perhaps feeling why he was born or wishing he wasn't born is a primary example of Job's mental breakdown as in terms of lament or a cry for help and relief.

Zuckerman calls this lament, "a lament of final resort," the function of which was "portray a sufferer's distress in the most nihilistic terms possible for the purpose of

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[9] Carol A. Newsom, "The Book of Job: Introduction, Commentary and Reflections," *New Interpreter's Bible*, 12 vols. (Nashville, TN: Abington Press, 1996), 366-367.

attaching God's attention and thus leading to the rescue of the sufferer from affliction.[10] As an implicit appeal, it is an act of faith.[11]

> Understood in this context, the announcement in Job 3:1 is perfectly in keeping the dynamics of the prose story and with the image of Job created there. Even in extremis he will curse the day of his birth, rather than God, his words of despair a tacit plea for deliverance. It is what the friends and readers expect, however, the actual words of Job overturn those expectations and decisively break open the closed world of the prose tale. Job subverts the conventions of the birthday curse through his radical use of (anti-) creation imagery, his inversion of divine speech, and his bitterly ironic description of life as oppressed and death as a valuable treasure. Whatever that is, it is not a tacit appeal for deliverance.[12]

Mental health and illness expresses itself in biblical terms of suffering, pain, mental or emotional anguish, depression or grief. Mental health affects the mental, emotional or spiritual condition, or pattern as relation to individual's thinking, mood or behavior that hinders a person from fully functioning spiritually, psychologically, socially or cognitively.[13] It is no different in the biblical account of Job's story as he expressed suffering, pain, mental and emotional anguish, depression and grief.

In looking closer at Job 3: 3-10, which states:

> Let the day perish in which I was born, and the night that said, 'A man-child is conceived. Let that day be darkness! May God above not seek it, or light shine on it. Let gloom and deep darkness claim it. Let clouds settle upon it; let the blackness of the day terrify it. That night—let thick darkness seize it! let it not rejoice among the days of the year; let it not come into the number of the months. Yes, let that night be barren; let no joyful cry be heard in it. Let those curse it who curse the Sea those who are skilled to rouse up Leviathan. Let the stars of its dawn be dark; let it hope for light, but have none; may it not see the eyelids of the morning— because it did not shut the doors of my mother's womb, and hide trouble from my eyes.

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[10] B. Zuckerman, *Job the Silent: A Study in Historical Counterpoint* (New York, NY: Oxford University Press, 1991), 125-126.

[11] Newsom, "The Book of Job," 366-367.

[12] Newsom, "The Book of Job," 366-367.

[13] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

Many persons that experience mental breakdown have described their experiences of being or seeing things dark and hopelessness. Job 3: refers to Job describing his feelings as dark with no light from morning and compares it to no life just like him never being conceived. Newsom describes these verses as the following:

> Job's speech divides into two major sections: the curse proper (vv. 3-10) and the lament over having been born (vv. 11-26). The former begins in [verse three] with a curse of the day of birth and on the night of conception. First day is cursed with a deprivation of light (vv.4-5). Then night is cursed with a deception fellowship and frustration of desire (vv. 6-9). Finally, the reason for the curse is given: the failure of that day to prevent Job's birth (v. 10). The object of the curse, identified generally as "his day" in [verse one] is divided into two distinct times, the day of his birth and the night of conception (v.3).[14]

Job cursing the day of his conception shows that he had a mental breakdown and is a result of his grief and loss. Many persons that experience depression and depression express that they feel like they were never born, just like Job. Many persons within the church and church leadership, are experiencing major depression from life experiences which it becomes hard to verbalize their feelings and to seek help. This could have been the plight of Job that connects all humanity.

Newsom describes Job's breakdown and curing the day he was born as: "Job's curse personifies the night as announcing the news of the conception. Since ordinarily birth announce rather than conception, some interpreters rationalize the image translating the Hebrews word as "born" instead of "conceived" or by assuming a textual error and reading "behold!" In doing so they underestimate the extravagant quality of Job's language."[15]

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[14] Newsom, "The Book of Job," 367.

[15] Newsom, "The Book of Job," 367.

"Day of birth" and "night of conception" are complementary terms in that conception and birth mark the beginning and end of gestation. "Night" and "day" are also complementary terms that designate the corresponding parts of a single day. The double resonance of these terms creates a poetically condensed image of Job's coming into being. It also allows Job to exploit the ambiguities of the term "day."

The day of one's birth might be understood to refer either to a unique historical day or to a calendar day that occurs once each year. Although the limited amount of evidence concerning such curses makes it difficult to know what was customary, the references in Sirach and in Jeremiah focus on the unique historical day.

Many times parishioners experience darkness as a result of life's difficult challenges such as loss of a job, loss of relationship etc. just like Job. The dominant motif in his curse of that day is the reversal of light into darkness. To deprive day of light is to deprive it from its essential characteristic, but it is also punishment that fits the crime. Since that day allowed Job to "see light" (cf. v.16), Job deprives that day of light. Six different expressions for darkness appear in verses four and five, but its most powerful formulation is the opening phase "that day-let it be darkness! A secondary motif reflects abandonment and possession. The third imagine assumes that light is not an intrinsic quality of day but something that must be given to it. This imagine of God's abandonment of day with the image of hostile possession by others. Job 3:11-26 states:

> Why did I not die at birth, come forth from the womb and expire? Why were there knees to receive me, or breasts for me to suck? Now I would be lying down and quiet; I would be asleep; then I would be at rest with kings and counselors of the earth who rebuild ruins for themselves, or with princes who have gold, who fill their houses with silver. Or why was I not buried like a stillborn child, like an infant that never sees the light? There the wicked cease from troubling, and there the weary are at rest. There the prisoners are at ease together; they do not hear the voice of the taskmaster. The small and the great are there, and the slaves are free

> from their masters. "Why is light given to one in misery, and life to the bitter in soul, who long for death, but it does not come, and dig for it more than for hidden treasures; who rejoice exceedingly, and are glad when they find the grave? Why is light given to one who cannot see the way, whom God has fenced in? For my sighing comes like[c] my bread, and my groaning's are poured out like water. Truly the thing that I fear comes upon me, and what I dread befalls me. I am not at ease, nor am I quiet; I have no rest; but trouble comes.

Westermann writes, "This section is often called a lament. That label can be misleading if one thinks in terms of the psalms of lament, where the individual addresses God directly and seeks relief. Here, even though some terms and images from the lament tradition are used, Job does not address his words to anyone in particular."[16]

What Job says is not a lament in the classic sense but rhetorical in the classic sense and is a rhetorical wish that one had never been born, which formally belongs to the curse on the day of one's birth. This wish never had been born is not the same as the wish to die, which a number of characters in the Bible express. Biblical culture shows that the people of that day was concerned about death and the afterlife.

Newsom describes the following verses in examining Job's death wish:

> "Many "request that a person should no longer continue to live, rather than the specific desire to that one had never lived or had died at birth." Job transforms that is briefly expressed wish in Jeremiah into a baroque fantasy of death. The death wish is expressed (vv.11-12) as the desire to have died as a newborn (v. 16) as the desire to been stillborn. In and 17-10, Job describes the advantages of such death with a reflection on the irony that life is given to those who crave death (vv. 20-24). Finally, Job concludes by stating the reason for his vehement curse (vv. 25-26). Job begins with rhetorical questions expressing the desire to have died during birth (v. 11) or, if not then to have been refused the life-sustaining nurture an infant requires. Why? If he had not been and suckled, Job says, now he would be lying down quietly and asleep (v. 13). With the bitter irony Job takes the image of the child who sleeps after feeding and applies it to himself as a child fortunately dead from lack of nurture. The images that follow are more perplexing, for it is not immediately clear why Job would speak of the company of rulers and wealthy princes as a particular feature of death (vv. 14-15). As the

[16] C. Westermann, *The Structure of the Book of Job* (Philadelphia, PA: Fortress, 1981), 37-38.

> greatest of all the people of the east" (1:3), Job certainly enjoyed their company in life." [17]

The meaning of the image is to be sought in the contrasts and similarities that the passage sets up between the lives and deaths of infants and magnates. Unlike the infant, the rulers engaged in intensive activity. This contrast is expressed most ironically in verse 14b, where the text says literally that they "built ruins for themselves." The phase captures the ambiguity of such activity. Ancient Near Eastern kings took pride in rebuilding ancient ruins of cities and temples.

Newsom suggests that Job's question of death becomes a rhetorical question in verse sixteen:

> Verse 16 resumes the rhetorical question of v.11. Job's desire for death is expressed in an image even more extreme. Here he envisions not the brief life of the infant but the stillborn child who "never saw the light." Parallel to the account of kings and princes now at rest, vv. 17-19 also describes the quietness that comes in death to various social groups who had been bound together in oppressive relationships, character characterized by agitation and exhaustion.[18]

"Wicked" in verse seventeen is a term that has not only moral but also specifically antisocial overtones.[19] Thus those "exhausted by power (v. 17b) are victims of the wicked, just as the captive corresponds to the taskmaster and the slave to the master.[20] Common to all of these relations were disproportion of power and an inability of the weaker member to resist the will and violent energy ("turmoil, troubling") of the stronger.

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[17] Newsom, "The Book of Job," 369.

[18] Newsom, "The Book of Job," 369.

[19] J. A. David, *Word Biblical Commentary Job 1-20* (Grand Rapids, MI: Zondervan, 1960), 53.

[20] E. Good, *In Turns of Tempest* (Stanford, CA: Stanford University Press, 1990), 56.

These are not idly chosen images; yet they seem initially incongruous for Job. He has said nothing about his particular suffering, the loss of possessions, servants, children, and health, even though that is what motivates his words. Somehow those specific losses have been transmuted during the seven days of silence (2:13) into these defining images of death and life. Perhaps these images indicate that Job's fundamental perception of the world changed. A person can survive devastating losses of the sense of the world as a fundamentally trustworthy place is still intact, as Job's words in 1:21 were meant to suggest. Now his images suggest that he perceives the world as crushing and inescapable bondage, from which death is the only release. It is tempting to interpret Job's use of imagines of social oppression as an indication that his sufferings have caused him to identify with the oppressed of the earth. As later chapters will show, however, Job's social perceptions, even shaped by his suffering, are complex (cf. Job 24 and Job 30).

The Book of Job as a Story of Mental Illness

The Book of Job becomes the backdrop for mental health illness as a result of life circumstances- loss and grief. Upon examining Job's faith in God and his blameless character does not exempt Job from facing life challenges and loss. Newsom states that:

> The Book of Job depicts a folktale or fictionist in which the main character [is] Job. Many scholars believe that this didactic story describes Job as being "blameless and upright, one who feared God and turned away from evil." (Job 1:1) This depiction of Job shows in traditional sense that Job had a relationship with God and his community. Job is also described [as] "the greatest of all the people of the east" (Job 1: 2). These were general moral and religious terms used in wisdom literature writings. "Fearing God" a traditional Hebrew term for respect and unsentimental piety. [21]

[21] Newsom, "The Book of Job," 345

This blameless character also does not stop Job from curing the day of his birth and having a death wish. Job's moral character does not exempt Job from also experiencing a mental health challenge and crisis. The text is clear that Job had a relationship with God and the community but still had to come to terms with his emotional mental breakdown. The mental breakdown of Job shows that all humans even Believers in God can face mental and emotional challenges.

The literary content shows that Job experienced three common patterns of storytelling as there is great tension and then a resolution. *The New Interpreter's Bible Commentary* argues that, "the conventions of a traditional storytelling, which often use patterns of three, the third repetition should provide both heightened tension and definitive resolution" which is occurring in Job the third chapter.[22] "The language of the Book of Job is "extremely high sophisticated, learned Hebrew, with a higher proposition of words unique to itself than any other book of the Hebrew Bible."[23]

Harper Bible Commentary discuss the literary part of Job being full of imagination, however this does not hinder the meaning of Job being a redemptive poetic of mental health in examining Job's relationship.

> From a literary standpoint, Job is one of the noblest works of world literature. Many scholars have difficulties placing Job in one category of literature but state that the book of Job expresses a range of poetic imagination and forms of hymns of praise to the Almighty (e.g. 5:8-16), laments of Job's dire fate (e.g. chapter 3, proverbs (e.g.4: 8-11; 5:1-7; 12:11-12; 14:1-2), and descriptions of blessedness of the righteous and the destruction of the wicked (e.g. chapter 8).[24]

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[22] Newsom, "The Book of Job," 366.

[23] Edwin M. Good, *Harper Bible Commentary* (San Francisco, CA: Harper and Row Publishers, 1988), 407.

[24] High Anderson, *The Book of Job: The New Interpreters One Volume Commentary* (Nashville, TN: Abington Press, 1971), 238.

Scholars refer to Job as "wisdom literature as wise men or sages of Israel were a special class characterized by their rationalistic and calculating approach to ethics, religion, and the problems of human life."[25] Many times the human experience of suffering mentally can be more challenging especially when a person like Job feels that he had not done anything to create this situation in his life.

High Anderson states the problem of innocent suffering in Job can be difficult to understand, "These constructed dialogues also addressed complaints about "innocent suffering and dealing with the problem of theodicy, which may he roughly defined as the problem of how to square belief in a good God with the existence of evil in the world.""[26]

Job's situation breaks traditions when he curses the day of his birth and questions why this has happened to him. Scholars believe that Job breaks traditional expectations and exceeds the hounds of a rhetorical gesture because of his great descriptive images concerning him cursing his birth, the announcement of his birth and speaking of darkness and not light shows that possibility of Job being in a dark place mentally, emotionally and spiritually. (Job 3:4-5) Job's reply of "What I have feared has come upon me; what I dreaded has happened to me. I have no peace, no quietness; I have no rest, but turmoil" (Job 3:25-26). This shows Job's emotional pain and loss in terms of a mental health challenge caused by suffering, loss, despair and his complicated grief.

The Book of Job addresses the problem of suffering and finding some help for anxiety and grief of Job. Scholars using words like anxiety, isolation and despair are clinical words used in the field of psychology in describing an emotional and mental

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[25] Anderson, *The Book of Job*, 238.

[26] Anderson, *The Book of Job*, 238.

status. "Some scholars believe that the common theme of dramatic unity is seen in the Book of Job as the author deals with "problem of suffering" and "finding sovereign God amid the whirlwind of despair, anxiety, and desolation."[27] Job discovers a new reality after his mental breakdown. Job becomes a new person as a result of his mental breaking point.

Newsom states that "scholars have referred to this book as "age of anxiety" as Job faces the darkish days of his life and becomes an angry man. The answer that Job receives is not an all-embracing philosophical solution to the torment of his soul. Rather, as we have seen, it is an experience, a direct confrontation with the sovereign God, in whose presence Job's self-righteousness and pride is broken, so that he is now given a new power of being and a new self."[28]

The story of Job's mental breakdown and challenges show that his language does not align with his righteous character. People that are experiencing mental breakdown verbal express words that they don't mean or make decisions that they would not make if they were not traumatized by life circumstances.

The influences of Job's friend show that his community of friends can be compared to the response of the community and religious leadership when dealing with mental health issues of others. There are wider issues at play when someone is experiencing mental health issues like Job.

Dhorme discusses the wider issues of Job: "It is important at the outset to lodge these issues within the wider context of Job studies. As noted above, there are many

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[27] Anderson, *The Book of Job*, 241.

[28] Newsom, "The Book of Job," 366.

literary features that have caused many scholars to see this work as a composite of some sort."[29] Polzin discusses the dialogues of Job's friends: "Most notable is the incongruity between the narrative framework and the poetry, some of the finest but most difficult in the Hebrew Bible. Job's character as described by God (Job 1:8 and 2:3) seems inconsistent with his turbulent speeches."[30]

> In addition, apart from Job 12:9, the covenant name, Yahweh, does not appear in the cycle of dialogues. There is an apparent contradiction between God's speeches in chaps. 38–41, which effectively put Job in his place and God's affirmation of Job at the expense of his friends in the final chapter (Job 42:7–8). It is claimed that the final two-fold restoration of Job's property and family subverts the entire point of the dialogues.[31]

Job's speeches show that Job's mental health challenges does not speak against his faith in God, perhaps it enhances his faith and trust in himself and God. The story of Job serves as a story of someone who experienced mental health issues of complicated grief and loss. Job being a man of faith in God and blameless did not stop Job from experiencing a mental health crisis. Job cursed the day of his birth and question why he was experiencing the trauma that he experienced, however it never compromised his faith in God.

Mental Health Analysis

Job 3:1-4 states, "After this Job opened his mouth and cursed the day of his birth. Job said: "Let the day perish in which I was born, and the night that said, 'A man-child is

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[29] Edouard Dhorme, *A Commentary on the Book of Job* (Camden, NJ: Thomas Nelson and Sons, 1967), 206.

[30] Tryggve N. D. Mettinger, "The Enigma of Job: The Deconstruction of God in Intertextual Perspective," *Journal of Northwest Semitic Languages* 23, no. 2 (1997): 6-9.

[31] Robert Polzin, "The Framework of the Book of Job," *Interpretation: A Journal of Bible and Theology* 28, no. 2 (1974): 183.

conceived.' Let that day be darkness! May God above not seek it, or light shine on it." The third chapter of Job shows Job experiencing great suffering which caused him to have regrets of being born. The tension described here occurs after seven days and nights of Job being silent. The opening phase, "After this" establishes the continuity with the seven days and seven nights of silence" as Job's friend sat with him.[32] This shows the third test of Job as the reader waits to see if Job would "curse God and die" (Job 3). Job's speech is pivotal and critical as the text states "he opened his mouth" (Job 3).

Many scholars agree that the book of Job describes Job as great man that loses his wealth and children and is subject to a painful disease after discussion between God and a character some scholars call "the Prosecutor." Job was "Expected to curse God because of his experience, Job refuses to do so." "Three friends come to comfort him in silence for seven days."[33]

Job's opened his mouth and cursed shows some sign of a mental challenge or depression that Job was experiencing. Job's possible "depression" (a "wanting to die") which was associated with the attacks of life, including severe health problems, loss of his family, a broken relationship with his wife, and the loss of everything he had. *The New Interpreter's Bible Commentary* states that many scholars believe that anyone cursing the day that they were born could be rhetorical gesture however, Job's curse takes energy of self-directed aggression and transfers it to external object, the day of his birth.[34]

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[32] Newsom, "The Book of Job," 366.

[33] Good, *Harper Bible Commentary,* 407.

[34] Newsom, "The Book of Job," 366.

The *New Interpreter's Bible Commentary* states that the book of Job begins as the character Job refusing to curse God. Scholars note, "Job curses (Job 3:1) not the deity but "his day of his birthday." His curse (v.4-5) alludes to creation: "That day, let there be darkness" (v 4a) parodies Gen 1:3; "Let there be light." By images of God's and God's absence, of darkness domination, avenging, and terrifying day, Job curses his birthday as a reversal of the first process of creation. In vv.6-7, his curse on the night of conception cancels time, which creation set in train."[35]

The *New Interpreter's One Volume Commentary of the Bible* describes the story of Job 3:1-26 as a flint in Job's heart. The writer describes this flint in Job's heart that has "stuck in his soul, and he curses his life in a way frequency do in their darkness hours: I wish I had never been born!"[36]

The *New Interpreter's One Volume Commentary of the Bible* also describes Job being moved from his peacefulness to chaos to possibility calling a very similar figure Leviathan (vs. 8; cf Ps.74:14; Isa 27:11), a Babylonian "primeval serpent monster of the sea which is a symbol of confusion mentioned in the Babylonian epics."[37] The text also may possible references to underworld of Sheol where death is present. This shows that Job had some mental, emotional challenge brought on his own loss, grief, and abandonment.[38]

Job's cursing and silence show that Job was experiencing a mental health challenge. As job suffered a major grief and loss, his suffering caused Job to experience a

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[35] Newsom, "The Book of Job," 366.

[36] Anderson, *The Book of Job*, 242.

[37] Anderson, *The Book of Job*, 242.

[38] Anderson, *The Book of Job*, 242.

mental health challenge that speaks through his long silence and his speech in Job 3. Theologian Dorothy Soelle describes the phases of Job suffering as necessary and describes it as "mute suffering."[39] She describes this as "a time of numbness and disorientation, in which a person experiences an acute sense of helplessness."[40] She continues to show Job's suffering as a mental challenge that forced Job into a deep mental state of numbness, silence and pain caused from his suffering, loss and grief by revealed by his prolonged silence and his cursing of the day he was born. Dorothy Soelle argues that:

> Extreme suffering can cause a person inward, making communication almost impossible and intensifying a sense of isolation. Suffering must find a voice before it can be worked on. This process is not an easy one, nor does it take place in the same way for everyone. The first two chapters of Job show him to make use of inherited words of proverbial wisdom to find a resolution for his grief. Perhaps because Job tried to resolve his suffering before he has adequately given voice to his enormity, his attempts fail, and he sinks into a prolonged period of suffering.[41]

"Cursing the night" (Job 3: 6-9) show that "thick darkness" becomes a dominant motif of these curses become "the denial of joy in relationships." Job 3:11, 16 describes Job's desire for death which seems to be his only relief. This also can describe many that are suffering in today's modern society.

Israelite religion is often admired for making a place of anger within religious language. The psalms of lament are particularity noted for allowing the speaker to articulate anger. The book of Job validates the leg of anger arising out of an experience of suffering, even when anger makes others uncomfortable, and even when the anger is

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[39] Anderson, *The Book of Job*, 242.

[40] Anderson, *The Book of Job*, 242.

[41] Newsom, "The Book of Job," 371.

directed at God. Anger that settles into bitterness is not the final resting place, but often the anger of suffering must be expressed and explored in all its dimensions before it can be transmuted into something else. What do Christians do with this anger and bitterness that occurred by life challenges? How can mental health help a person deal with this anger and bitterness? What are the effects of unresolved anger and bitterness?

Job's curse on the day of his birth provides a token of hope because it marks his ability to enter the phase of suffering in which muteness is replaced by speaking. This "finding a voice" become helpful through mental health counseling. Mental health counseling can aid in helping people that are suffering find their voice to experience and receive the healing and deliverance that they need. Scholars call this phase "changing" and describes it as a place in which the "active behavior is possible, objectives can be identified, and solidarity with others persons form new community."[42] This changing and identifying that Job is doing in Job the third chapter, is the main purpose of mental health counseling which help people discover and form new meaning for themselves, others and God. Job finds this strength from counseling himself that helped him overcome the power of suffering. Job's withdrawal into permanent silence would have been a withdrawal into despair and apathy, however Job's ability to speak of his devastation and suffering becomes a sign of hope and healing for Job. This is the main purpose of mental health counseling which helps persons "voice" their feelings, provide a place of healing and restoration like Job experienced.

[42] Newsom, "The Book of Job," 372.

Mental Health and the Community's Response

Job's community of friends and their response to Job's life disruption and mental health challenge is very important in this story because it parallel's the current response from the church at large in the twenty-first century to mental health. Newsom explains when referring to Job's friends in response to his suffering:

> Job's friends are often summarily dismissed as having little concern for the depth of his suffering and as being far too quick to condemn him on the assumption that his afflictions were the result of sin. While it is true that their theological pronouncements did not fit Job's circumstances, it is equally true that they all shared a basic traditional sense of divine justice without which the whole moral nature of the universe would be upended.[43]

Most often when someone is facing a mental health challenge or mental breakdown, the religious community of questioning suffering as a result of sin or something that someone did wrong.

Robert Polzin explains that Job's friends were more concerned with divine justice as a result of sin than the feelings and suffering of Job. Newsom explains, "The friends manifested an abiding concern to defend that system of divine retributive justice which, in their minds, was under attack with every utterance of Job. For his part, Job uttered such shocking words that numerous scholars have separated the poetic chapters from the narrative framework in which Job's integrity and piety were noted by God himself."[44] The response of the religious community as representations of Job's friends caused his friends to have to apology to Job for their wrongdoings and false accusations against Job.

Duck-woo explains Job's speech as possibly an expression of his feelings and as constructive not necessarily destructive. "Job's speeches were destructive. This

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[43] Newsom, "The Book of Job," 90–91.

[44] Polzin, "The Framework of the Book of Job," 183.

interpretation helps to smooth the irregularity between Job 38:2 and Job 42:7. Job's speeches were not destructive. Rather, he took a new look the God of power and freedom rather than simply the God of justice and mercy."[45] In helping persons that are experiencing mental health challenges, the church must be willing to focus on the God of healing than simply the God of justice so that people can experience the power of God and healing.

Newsom evaluates Job's friends' responses to Job's mental breakdown as a misunderstanding of Job's experience,

> Job's ongoing commentary regarding his friends was blistering. They added to his torment (Job 19:2) and they pursued him as badly as God did (Job 19:22). They were liars and would be best off if they kept silent (Job 13:4–5). He nailed the problem inherent in each attempt to counsel him: "Will you speak wickedly on God's behalf? Will you speak deceitfully for him?" (Job 13:7). This is an adumbration of God's rebuke to Eliphaz at the end; indeed, they had not spoken truthfully because their words for Job's context were false. They erred in consistently slipping Job into their moral formulas, subtly at first but egregiously at the end. All of this, in effect, constituted "false testimony" because it ran counter to the public witness to his character (cf. Deut 19:16–19).17 The friends had to be held accountable for what they did know, Job's long-term reputation and his own testimony. In keeping with Deuteronomy 19:19 regarding false testimony, punishment would be forthcoming and, in the end, God required of them a penitential sacrifice.[46]

Perhaps Job's friend misunderstanding of Job's experience and response can serve as a reminder to religious communities as a responsibility to care for persons that face mental health challenges and breakdown. Job's friends were held accountable for their treatment of Job and his experience according to the text.

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[45] Duck-woo Nam, *Talking About God: Job 42:7–9* (New York, NY: Peter Lang, 2003).

[46] Elaine A. Phillips, "Speaking Truthfully: Job's Friends and Job," *Bulletin for Biblical Research* 18, no. 1 (2008): 31-43.

Many scholars describe Job's initial outburst or mental disruption as he wrestles with life and possible death (Job 3). Robert Polzin describes the patience of Job in response to his friend's abandonment as "some of the most anti-Yahwist sentiments of which we have any record in literature....[replete with]....audacity, defiance, and self-righteousness."[47]

Phillips describes the patience of Job as an important quality as Job defends himself against his friends and wrestle with mortality and suffering.

> In anguish, Job oscillated between a strong desire for death and a fierce will to survive, to confront God, and to find hope in vindication. Job's testimony to God's gift of life (Job 10:12) gave way to his wish that he had not lived following his birth (Job 10:18) and a plea that God turn away from him so that he might have a fleeting moment of joy before the utter darkness of death (Job 10:21–22).[48]

The story of Job and his friend's show implications of God's Sovereignty for Job. Phillips states that:

> Although Job repeatedly expressed his disappointment with his friends (Job 6:14–27; 12:2–5; 13:2–12; 16:2–5; 19:2–6, 21–22; 26:2–4), most of his words were either addressed to God or protested the horrifying condition into which God had brought him. Job referred to God as Almighty (Shaddai) but not benignly so; instead, the Almighty's arrows were in him and the terrors of God were arrayed against him (Job 6:4). In tones of perplexed outrage, he questioned why the One who shaped him so carefully would destroy that product of his creativity (Job 10:8–12).[49]

The fact is that Job needed help and support in his time of suffering just like person experiences mental health challenges and breakdown. Job's story serves as a reminder that God is sovereign and able to help those that are in need physically and mentally. Phillips states,

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[47] Phillips, "Speaking Truthfully," 31-43.

[48] Phillips, "Speaking Truthfully," 35.

[49] Phillips, "Speaking Truthfully," 36.

> Nevertheless, the deeper Job's darkness and the more dreadful his perception of God's sovereignty, the greater was his faith. In the midst of his strongest declarations of God's responsibility for his own plight (Job 9:30–31; 16:7–14) and the comprehensive evil in the world (Job 9:24; 21:1–21; 24:2–12; 27:2), Job longed for a mediator, advocate, and intercessor (Job 9:33–34; 16:19–21)—one who *could and would* restore the lost relationship. Initially, his words were uncertain about the possibility of an arbitrator, even though he needed one so desperately.[50]

Many persons facing physical and mental health challenge and breakdown need advocates, intercessors and support in order to move and grow in their faith, however many persons just like Job's experience do not receive the support and compassion that they need so they can be restored and encouraged.

New Testament

Mark 5:1-20 states:

> They came to the other side of the sea, to the country of the Gerasenes. And when he had stepped out of the boat, immediately a man out of the tombs with an unclean spirit met him. He lived among the tombs; and no one could restrain him any more, even with a chain; for he had often been restrained with shackles and chains, but the chains he wrenched apart, and the shackles he broke in pieces; and no one had the strength to subdue him. Night and day among the tombs and on the mountains he was always howling and bruising himself with stones. When he saw Jesus from a distance, he ran and bowed down before him; and he shouted at the top of his voice, "What have you to do with me, Jesus, Son of the Most High God? I adjure you by God, do not torment me." For he had said to him, "Come out of the man, you unclean spirit!" Then Jesus[b] asked him, "What is your name?" He replied, "My name is Legion; for we are many." He begged him earnestly not to send them out of the country. Now there on the hillside a great herd of swine was feeding; and the unclean spirits[c] begged him, "Send us into the swine; let us enter them." So he gave them permission. And the unclean spirits came out and entered the swine; and the herd, numbering about two thousand, rushed down the steep bank into the sea, and were drowned in the sea. The swineherds ran off and told it in the city and in the country. Then people came to see what it was that had happened. They came to Jesus and saw the demoniac sitting there, clothed and in his right mind, the very man who had had the legion; and they were afraid. Those who had seen what had happened to the demoniac and to the swine reported it. Then they began to beg Jesus to leave their

[50] Phillips, "Speaking Truthfully," 37.

> neighborhood. As he was getting into the boat, the man who had been possessed by demons begged him that he might be with him. But Jesus[e] refused, and said to him, "Go home to your friends, and tell them how much the Lord has done for you, and what mercy he has shown you." And he went away and began to proclaim in the Decapolis how much Jesus had done for him; and everyone was amazed.

Mental health or illness is any life condition (emotional, psychologically or spiritual) that disrupt a person's thinking, feeling, mood, ahility to relate to others and daily functioning which diminishes one's capacity for coping with the ordinary demands of life and disrupts our social or spiritual connection that God wants us to enjoy. Mental health or illness expresses itself in biblical terms of suffering, pain, mental or emotional anguish, depression or grief. Mental health affects the mental, emotional or spiritual condition, or pattern as relation to individual's thinking, mood or hehavior that hinders a person from fully functioning spiritually, psychologically, socially or cognitively.[51] It is no different in the biblical account of this man's story as he expressed suffering, pain, mental and emotional anguish, depression and grief which is seen in this man's story.

Pherigo describes Mark as one of the earliest gospels, he states:

> Modern scholarship is in broad agreement with the 2nd century traditions written by Mark, a missionary companion of Peter and Paul. Scholars believe that Mark was written in Rome, far away from the traditions of Jesus and dates 35 years after the events might have occurred. Scholars believe that Mark was one of the earliest gospels was used independently by Matthew and Luke after the death of Peter. Mark presents Jesus from the Gentile Christian as Christianity was in transition from the Semitic culture of Palestinian Judaism to the Gentile culture of Roman Empire.[52]

Donahue states that the story of the Gerasene demoniac is a very detailed story and is entrenched in folklore and demoniac exorcism. He states, "The exorcism of the Gerasene

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[51] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

[52] Lindsey P. Pherigo, *The Gospel According to Mark, The New Interpreters One Volume Commentary* (Nashville, TN: Abingdon Press, 1971), 644.

demoniac (5:1-20) is one of the longest and vivid of the NT miracles. Mark has adopted an early folklore narrative to his theology. The narrative follows the normal patterns of exorcisms as first meeting the demoniac and the exorcist; second silencing and expulsion of demon by exorcist; and third departure of the demon, with rejection of onlookers."[53]

In examining this story and experience of this man, there are many factors around the man's mental health and psychological condition. During biblical times, the thought was that anything dealing with mental breakdown and erratic behavior was addressed as demonic possession rather than a medical condition due to their lack of knowledge on the subject. Perkins states,

> Mark 5 shows that suicide and human suffering of this man at Gerasa known as the demonic legion by some scholars. Many religious scholars have attempted to addressed mental health as related to demon possession as related in this biblical text found in the book of Mark with the Gerasene man. Mark's text of Gerasene Demonic in 5: 1-20 reveal to the reader the different barriers of ethnicity, race, class, gender and mental illness in the religious and political community.[54]

This acknowledgment of mental illness in a religious and political community helps to set the stage of the community's response concerning his mental health situation. The book of Mark uses the exorcism language intentionally to demonstrate Jesus's power over evil.

> Use of exorcism language provides a cosmological context for the story. Just as the sea monster in ancient mythology represents the powers of evil, so also the raging storm here reflects all the powers of chaos and evil. Jesus' exorcisms are evidence that he is the stronger one, ahle to break up Satan's kingdom (3:23-27). Mark refocuses this impressive demonstration. The lack of a request to the deity raises the question of whether the disciples believe that Jesus can rescue them.[55]

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[53] John R. Donahue, *Harper Bible Commentary* (San Francisco, CA: Harper and Row Publishers, 1988), 990.

[54] Pheme Perkins, *The New Interpreter's Bible Commentary*, vol. 8 (Nashville, TN: Abingdon Press, 1994), 582.

[55] Donahue, *Harper Bible Commentary*, 990.

This story is saturated with political and religious tension, however among the situation that there is a male experiencing a mental health challenge and breakdown. "The ominous signs of social and religious chaos attached to this story are as dramatic as the storm at sea that attended the crossing." [56] Unfortunately, once again, a person that is seriously in need, is ignored and rejected from the community

Community of Gerasa

Biblical scholars state and believe that, "The city of Gerasa was one of the ten cities of the Decapolis, which lay across the Jordan in the territory ruled by Philip."[57] "Geographically, Jesus has ventured well into Gentile territory. The description of the locale within the story, however, fits none of the traditional sites, since Gerasa lies thirty miles southeast of the sea. Jesus is breaking down barriers that separate Jews from Gentiles, clean from unclean. The sea, which might have been a barrier between the two ways of life, will hereafter be crossed repeatedly."[58] The sea does serve as metaphoric division between the two worlds, the same division between many persons experiencing mental health and their community and the church.

Freyne describes the conditions of this man in the community as "The demoniac's condition forms the antitype to the civilized, Hellenistic city nearby. He lives like a wild animal among the dead, and repeatedly injures himself because not even the most primitive form of human restraint chains, can contain him."[59]

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[56] Perkins, *The New Interpreter's Bible Commentary*, 583.

[57] S. Applebaum and A. Segal, "Gerasa," in *The New Encyclopedia of Archaeological Excavations in the Holy Land*, ed. E. Stern (New York, NY: Simon and Schuster, 1993), 470-479.

[58] Sean Freyne, *Galilee, Jesus and the Gospels: Literary Approaches and Historical Approaches Investigates* (Philadelphia, PA: Fortress, 1988), 54-55.

[59] Freyne, *Galilee, Jesus and the Gospels*, 54-55.

Many biblical scholars agree that this story is very expansive beyond the normal folktale story as the conditions before heighten the impact of the man's story and condition. Guelich describes this man's story as being:

> Much more expansive than a normal exorcism story. It ends with two reports about the episode: (11 swineherds rush to carry news to the city (v. 14], and (2) the cured demoniac begins spreading throughout the Decapolis the news about what Jesus has done (v.20). In addition, the extended description of the man's condition (vv. 3-5) heightens anticipation over what will happen when he encounters Jesus. Finally, the description of the swine's being drowned, which fits the geographical assumptions of Mark's Gospel that the episode took place near the sea, was probably added to a description of a disturbance among the swine that demonstrated the demons' departure.[60]

Notice the terms of separation are very apparent in this narrative. Perkins describes the condition and the community of this man in terms of separation and division, clean and unclean:

> Jewish ritual practices separate the world into categories of clean and unclean. When heard within that context, the elements of impurity in this story are piled one upon another: unclean spirit, dwelling among tombs, and a large herd of swine. This description may also be a deliberate echo of Isa 65:4-5, where the nation that should seek God has lapsed into impure paganism and its citizenry dwell among tombs at night, eat swine's flesh, brew abominable things, and claim to be holy. Mark's Gentile reader may not have sensed the anomaly of Jesus' venturing so dramatically into the chaos of ritual impurity as would Jewish readers, but the description of the possessed man raving among the tombs would evoke the honor of being outside the ordering power of civilization.[61]

This man lived among the tombs which shows that he was not part of the regular society and community. Perkins continues to focus on his behavior and mental challenge that placed this man against humanity. "The dramatic expressions of the man's completely asocial behavior, even to the point of howling like; a wild animal rather than using language (v. 5), makes the point dramatically enough for any reader. The demons have

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[60] Robert Guelich, *Mark 1-8:20* (Dallas, TX: Word, 1989), 273.

[61] Perkins, *The New Interpreter's Bible*, 583.

stripped this man of every shred of humanity."[62] Many persons facing mental breakdown and psychological challenges cause many people to judge them and not think of them as human with feelings. Many persons avoid them instead of trying to show compassion and love toward them.

Perkins describes the challenge of this man and his lack of human contact:

> Unlike the demoniacs earlier in the story, this man has been driven from all human contact. God created humankind in the divine image (Gen 1:26); this man, however, appears to have lost even the "image of God" that makes him human. Like the demons preceding in earlier stories, this man immediately recognizes that Jesus is the Holy One of God. Unlike the earlier stories, this recognition takes place at a distance. Although his rushing up to prostrate himself before Jesus suggests a gesture of worship appropriate to Jesus' identity (v. 6), the demoniac's words reflect a desire to drive Jesus away that is characteristic of the exorcism genre (v. 7).[63]

This juxtaposition may have belonged to the tradition as Mark knew it, since he explains the demon's response by telling readers that Jesus bad already told the demon no leave (v. 8).[64]

"Legion" – A Reference to Mental Health

The reference to the name Legion has a significant meaning and reference to destruction. Based upon numerous biblical scholars the name "legion" can suggest a negative reference as the destroyer of property and people from Roman ruler.[65] Perkins

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[62] Perkins, *The New Interpreter's Bible*, 583.

[63] Robert H. Gundry, *Mark: A Commentary on His Apology for the Cross* (Grand Rapids, MI: Eerdmans, 1993), 259.

[64] Perkins, *The New Interpreter's Bible*, 583.

[65] Dieter Luhrmann, *Das Markusevangelium*, HNT (Tubingen, Germany: J. C. B. Mohr Paul Siebecki, 1987), 100.

describes and provides the details of the exchange between Jesus as a comparison to the exorcism story of that day.

> The verbal exchange between the demoniac and Jesus expands the concise pattern of earlier exorcism stories (see Mark 1:23-27). Readers know that Jesus silenced the demons because they were identifying him as Son of God (3:12). This identification was an attempt to ward off the power of the exorcist. Here, the demon engages in an even more elaborate exchange. He first approaches Jesus as suppliant, kneeling before him (v. 6). He then attempts to invoke God's name to drive Jesus away (v. 7). A second exchange between Jesus and the demon forces the demon to reveal his name (v. 9). This revelation provides a striking explanation for the terrible situation in which this man has found himself. At full strength, a legion consisted of 6,000 infantry, 120 cavalry, and associated auxiliaries. The term *legion* might also be used for a battalion of 2,048, which is closer to the number of pigs in the herd. An astonishing visual image results: As soon as Jesus steps into this Gentile territory, a legion prostrates itself before him. God's kingly power has subdued imperial domination.[66]

As we examine the story of Jesus as a context for mental health, Jesus was not afraid to help this Gerasene man. The text shows that the mental breakdown of this man was very dangerous to himself and the community. However, it was not a match to the authority of Jesus to provide healing and restoration to this mental situation of this man.

> The story type requires some evidence that the individual has been cured. In this case, the swineherds, fleeing in terror from the epiphany of divine power in Jesus, bring people out from the city. They see that the man who was once completely asocial is in his right mind and wearing clothes (v. 15). Like the demon, the citizens also want Jesus to leave the area (v. 17). Mark does not supply a reason for that request, although suspicion of Jesus' power over the demons (similar to the earlier charges that Jesus was in league with Satan [3:22]) could be presumed to be the reason. Concern over the economic loss of the herd of pigs would seem to be a less likely motive in a story that originated among Jews, who considered swine unclean.[67]

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[66] Perkins, *The New Interpreter's Bible,* 584.

[67] Perkins, *The New Interpreter's Bible*, 584.

The territory of this city serves as a reminder of division and divide. Even the name "Legion" shows that the division from the community and him being marginalized from his community, a civilized society. Metaphorically, the sea represents a barrier a divide.

> This text takes place in the city of Gerasa as one of the ten cities of Decapolis. Decapolis is located the Jordan territory ruled by Phillip. The story has Jesus going into Gentile territory which becomes significant for the story. The location does not fit the traditional sites as Jesus is making a point which is central to his message of addressing the barriers of separate between the Jews and the Gentiles and from clean to unclean.[68]

"The sea, which might have been a barrier between the two ways of life, will hereafter be crossed repeatedly."[69]

> There Jesus and the people encounter a man living with a mental condition that presents himself to a civilized Hellenistic society as a wild animal living among the dead and repeating injuring himself. This represents a non-primitive form of human resistance as the chains were not able to restraint him. There was a mental illness that seem to have controlled this man. The man was uncontrolled by the restraints of his society. This man perhaps [was] dangerous to his society and an outcast due to his uncontrollable behavior. This man was considered unclean according the Levitical Law and his social behavior. This man was stripped of his humanity. This man lived in the tombs with the dead people. His name was Legion, perhaps a representation of the devastation of people and property covered by Roman occupation. Legion also represented 2,048 pigs in a herd. Jesus's response and mission was to restore this man to his humanity.[70]

Jesus empowered this man to preach the good news. "Demons traditionally harass and take over a person's personality, therefore it was Jesus's mission and goal was to show the healing for this man." There were many social, political and gender barriers in this Hellenistic community, however Jesus's mission bring the good news and restored humanity back to these people.[71]

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[68] Perkins, *The New Interpreter's Bible*, 584.

[69] Freyne, *Galilee, Jesus and the Gospels*, 54-55.

[70] Perkins, *The New Interpreter's Bible*, 584.

[71] Perkins, *The New Interpreter's Bible*, 583-584.

In looking at the biblical text concerning demons and mental illness, we must examine at these assumptions. The first assumption is that in "biblical times individuals were inclined to attribute demons to unusual behavior and untreatable illness that because of their pre-scientific worldview and naive understanding of disease and mental illness cannot otherwise be explained."[72]

The second possibility and assumption is that "incidents of demon possession and infirmity were limited to biblical times and the ministry of Jesus and the apostles."[73] The third possibility and assumption "is the demon infirmity and possession still occurs today much as they did in biblical times."[74] In all essence of beliefs, "the infirmed require healing, which may come through medical intervention or though answer to healing prayer. In either case, healing is the focus, rather than deliverance."[75]

Mental Health Analysis

Mark 5:3-5 states: "He lived among the tombs; and no one could restrain him any more, even with a chain; for he had often been restrained with shackles and chains, but the chains he wrenched apart, and the shackles he broke in pieces; and no one had the strength to subdue him. Night and day among the tombs and on the mountains he was always howling and bruising himself with stones." The biblical text is clear that this man was experiencing a mental health breakdown due to the fact that he had to be restrained

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[72] Perkins, *The New Interpreter's Bible*, 582.

[73] Perkins, *The New Interpreter's Bible*, 582.

[74] Perkins, *The New Interpreter's Bible*, 582.

[75] Matthew S. Stanford, *Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness* (Downers Grove, IL: InterVarsity Press, 2008), 33-35.

with shackles and chains which still could not subdue him. This man was defined by his life disruption and condition. All day and all night he lived in the mountains and was "bruising himself with stones."

Suicide and suffering are major themes of this man's experience. The cutting of himself and bruising himself with stones are possible signs of suicide which the ancient culture did not address from a psychological base. Mark the fifth chapter shows that suicide and human suffering of this man at Gerasa known as the demonic legion by some scholars. Suicide and suffering in the Bible show that the biblical characters experienced hardships that left them suffering, in despair and without hope which can express itself as a mental health challenge. Suicide must be addressed in the terms of suffering and mental health. In reviewing the terms of suicide in the Greek culture, mental health and suffering, many persons in this man's mental condition could cause harm to self or others due to the psychological instability. The man had the potential of being suicidal if he did not get treatment and healing by Jesus.

Pheme discusses the Greek culture and the questioning of suicide by indicating that:

> The consideration relative to the right of a person to terminate his or her own life and to one's duty to the plans of another person to terminate his or her own life. The question of suicide as an ethical issue is as old as the Greek philosophers by whom it was discussed at great length. The topic was surprising of little concern, however, to the biblical writers who did not think of suicide as moral or ethical issue. These are few incidents of suicide in either OT or NT and those who reported without moral judgment.[76]

Suicide does not seem to be an issue until the early church. "It was during the time of the early church when some were seeking martyrdom too easily that the issue became

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[76] P. W. Pretzel, *Dictionary of Pastoral Care and Counseling*, ed. Rodney Hunter (Nashville, TN: Abingdon Press, 2005), 1233.

relevant. St. Augustine was among the first to take a position that suicide is an affront to God, and so the faithful should not seek their own death."[77] If this man was suicidal or not, it still does not take away the fact that this man was suffering, misunderstood and isolated from the regular public life due to his condition. This man was defined by his condition.

Mental Health and the Community's Response

This man experienced isolation and was misunderstood in his community. He was most likely declared unclean due to his social behavior according the rules of the society. Being "unclean" and set apart has its own psychological responses from the community. This man becomes an example of how the community treated his mental health condition. "People who are mentally ill often have the feeling that they are "unclean" and therefore "set apart."[78] Robert Alders states that the:

> Stigmatization associated with both leprosy and mental illness elicits feelings of "disgrace shame within the afflicted as well as the affected person. These dynamics have a profound effect, upon the sufferer and her or his family that prompts a devaluation of the whole families' worth and value. The net result is a progression of evaluative judgments by others, resulting in depersonalization, dehumanization, and finally "demonization" of one afflicted. Such attitudes detract from the integrity and respect that deserves to accorded to all people, irrespective of their diagnosis. It stands to reason that the conspiracy of silence surrounding mental illness is alive and well because humiliation experienced in such a diagnosis exacerbates the phenomenon of denial, which in turns precludes possible treatment and care.[79]

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[77] Pretzel, *Dictionary of Pastoral Care*, 1233.

[78] R. H. Albers, W. Meller, and S. Thurber, *Ministry with Persons with Mental Illness and Their Families* (Minneapolis, MN: Fortune Press, 2012), 3.

[79] Albers, Meller, and Thurber, *Ministry with Persons with Mental Illness*, 3

Perkins expresses and summarizes the mental challenges of this man's experience and story as:

> The story of the man possessed by legion pits Jesus against the breakdown of every civilizing and humanizing power. Some of the mentally ill homeless persons in large cities, especially those who exhibit violent behavior, evoke the same fear and repulsion in people today that the demoniac must have inspired in ancient Palestinians. Unlike the possessed man in Mark's story, most of the homeless and mentally ill persons in our cities continue to wear clothes, use language, and appear to be functioning members of human society in other interactions with people. Yet volunteers at homeless shelters or at homes for the mentally ill often struggle to overcome their fear and aversion of the persons they are trying to help. But if volunteers do overcome that fear and aversion, they are often surprised to discover human beings beneath the rags, smell, and foul language. They may also become sensitive to the ways in which other volunteers keep the clients at a distance.[80]

In comparing the community's response to this man and Jesus moved past the social and political restraints as he provide healing and restoration for this this man.

> When the man is healed, he progresses from the non-human life of a rabid animal to that of a person with a home and friends. But be does not return home to take up life as usual. Healing has given him a new mission: to let others know that God's healing power can overcome the worst evils in human experience. Healing has a mission. It involves transformation, not mere restoration to the status quo.[81]

Healing becomes the mission and purpose to move from the status quo to a universal understanding of compassion and love as we learn how to help persons that are suffering. The community response should be agents of healing, restoration which challenges the status quo.

As we examine these biblical characters in the third chapter of Job and the fifth chapter of Mark, we can we learn as caregivers in helping people that are experiencing a mental health challenge biblically? How did the community care for these suffering

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[80] Perkins, *The New Interpreter's Bible Commentary*, 585.

[81] Perkins, *The New Interpreter's Bible Commentary*, 585.

people that experienced a mental health challenged biblically? What can we learn biblically from these two characters about life disruptions and mental health biblically?

The Old Testament speaks of mental health through Job's experience of suffering, loss and grief as Job cursing the day of his birth and explaining the response of his community of friends. The New Testament speaks of mental health through the demon possessed man named "Legion" who experienced a mental health challenge, the community response to his mental health challenges and Jesus' response of restoration and healing of this man.

Mental health issues are seen in both the New and Old Testament as a witness to the effects that mental health have on spiritual leaders as well as individuals in a congregation in terms of depression, suicide, suicidal ideation as being against God's plan for caring and wellness.

Mental health is a major theme in the biblical account as referenced and related to the mind and spiritual understanding. The church has been very silent and has not effectively addressed its concerns from a mental health, biblical or social context. The church has been biblical irresponsible and very ignorant due to their lack of understanding of psychology and mental health. The biblical text addresses many accounts as a reference to mental health as mental illness. Societal attitudes and the Christian church in response to mental illness has been that of separation and sometimes an over spiritualization of a mental illness.

These biblical accounts show strongly the ineffectiveness of the church and the religious leaders regarding the treatment of the person affected by mental health. Secondly, these accounts show the need for mental health awareness and competencies

for religious and spiritual leaders. Thirdly, these accounts show the need for the church and religious need for clinical training in order help persons affected by persons baving a mental healtb challenge.

Conclusion

The lives of Job and Legion characters show tbe psychological and societal treatment of persons facing mental health challenges. In examining the treatment of their mental breakdown of these two individuals and their experiences become the foundation in understanding mental health from a biblical perspective. The labeling and the response of the community and institutional stigma of persons suffering mental health issues were major issues within the time of Job and Legion. These stigmas and treatment of persons facing mental health still continue to be a major issue with the life of the church and the community especially in the African- American community. As we examine the biblical characters of Job in the third chapter and Mark in the fifth chapter, we can learn as caregivers in helping people that are experiencing a mental health challenge biblically? How did the community care for these suffering people at experienced a mental health challenged biblically? What can we learn biblically from these two characters about our own life disruptions and mental health biblically?

These two biblical passages are foundational in the doctor of ministry project. Within the lives of this biblical character's personal and mental health experiences and challenges show the need for mental health education and services within the community and churches. These two biblical passages show that everyone at some point in their lives will face a mental health challenge. Secondly the community, especially the religious

community has a lack of understanding of the importance of mental health education and services. Third, the two biblical passages show that mental health wellness and healing is needed in order for persons to live wholesome lives as people of God.

Mental health or illness is any life condition (emotional, psychologically or spiritual) that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning which diminishes one's capacity for coping with the ordinary demands of life and disrupts our social or spiritual connection that God wants us to enjoy.

CHAPTER THREE

HISTORICAL FOUNDATIONS

In this chapter the discussion occurs is centered on how communities have dealt with mental health and illness through the centuries within various communities. The chapter will also address questions such as: how the church has help or hindered mental health and wholeness? How did societies address mental health and person dealing with mental health challenges?

Mental health and illness is any life condition (emotional, psychologically or spiritual) that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning which diminishes one's capacity for coping with the ordinary demands of life and disrupts the social or spiritual connection that God wants us to enjoy. In examining the working definition for mental health and illness we hope to address these questions that are proposed.

The church and its congregants had to face life conditions that disrupted how people think, feel and their ability to cope with the ordinary demands of life. The church has provided a place that persons could turn to for healing, relief and restoration, however because of a lack of knowledge concerning mental health and treatment, mental health continues to be a mystery for the church. As a result questions like: how were people with mental illness viewed from a historical and church perspective? There is always a fascination and also a misunderstanding historically in our society concerning mental

health. The church has tried to make mental illness into a spiritual concept such as attributing such things as "spirits" or "demons" or "supernatural spirits," which lead to much human torture and confusion.

"The health or sickness of the mind has been a perennial concern of human societies through the centuries. In most ancient cultures, madness was attributed to possession by supernatural spirits."[1] Torture was often the a "treatment of choice," as epitomized by the practice in Neolithic cultures of drilling holes in the skull to allow evil spirits to escape (trepanation). Healthy-mindedness was assured by participation in sanctioned rituals, observation of taboos, and the use of magical devices (amulets, talismans and fetishes). These measures not only protected from demonic forces, but conveyed solidary with one's community and favor with its gods.

Religious caregiver however became leaders of helping to revive persons from the suffering and torment of these "spirits" or "demons. "Caregivers were usually priests or shaman-type religious functionaries who appeased the gods or exorcised demons."[2] This become very vital because religious leaders from leaders of the religious ceremonies to helping to relieve the pain and suffering of the mentally challenged.

Pre-Middle Ages

The Pre-Middles Ages address the shaman being viewed as a person that has a mental health challenge due to mystical behavior and their interactions with the spiritual world.

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[1] C. S. Aist, *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abington Press, 2005), 711.

[2] Aist, *Dictionary of Pastoral Care*, 711.

> From the dawn of recorded history comes information about the first medicine man—the shaman. The shaman was often distinguished by having mental illness. This allowed him to have visions and, it was thought, enabled him to communicate with the spirit world, which was believed to be the cause of all disease and physical illness. Drinking alcohol or ingesting hallucinogenic herbs might further enhance these "powers." As a result, mental illness was often highly regarded and respected in primitive societies.[3]

As the society advanced this type of behavior began to change from a spiritual or mystical view to a physiological view which involves process in the brain.

> As civilization advanced, severe mental illness (also called "madness" or "insanity") came to be understood as resulting from a disordered physiological condition. The Greeks in the fifth century BCE argued that hallucinations, delusions, or unusual mental excitement were due to an imbalance of the four humors (yellow bile, black bile, blood, and phlegm), not the work of gods or spirits. Mental illness, along with epilepsy, was called the "sacred disease" in the Hippocratic tradition: "those maddened through bile are noisy, evil-doers and restless, always doing something inopportune . . . But if terrors and fears attack, they are due to a change in the brain."[4]

Later the insane as they were called, became protected by law due to safety concerns.

> Graeco-Roman law made provision for the care of the mentally ill (largely by secluding them) to keep them from harming themselves or others. Nevertheless, care for the insane was generally considered a family responsibility, since there were no asylums or places to house the mentally ill. If severely disturbed, they might be restrained at home or, failing that, allowed to wander in the streets.[5]

The public perception later changed as people were concerned about the safety of the civilized society and the safety of the mentally ill.

> From the public's perspective, the mentally ill person in Greek and Roman times was no longer seen as special and gifted (as the shaman had been in early antiquity). Instead, he or she was viewed as strange and deranged, someone to be feared. A popular belief was that evil spirits were causing the illness and might fly out and possess others around the person.[6]

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[3] Harold G. Koenig, *Faith and Mental Health: Religious Resources for Healing* (West Conshohocken, PA: Templeton Foundation Press, 2005), 17-18.

[4] Koenig, *Faith and Mental Health,* 17-18.

[5] Koenig, *Faith and Mental Health,* 17-18.

[6] Koenig, *Faith and Mental Health,* 18-19.

"In ancient Greece and Rome, people with mental illness were shunned due to popular belief that their illness was caused by evil spirits that might fly out and possess the people around them. Ill people were considered the responsibility of their families, with no hospitals or asylums to house or care for them."[7]

"Christians prescribed religious treatments in the mid-fourth century CE, since at least some cases of mental illness were thought to be due to possession by demonic spirits."[8] Many times Christians included prayers for the sick. These "Prayers were included in the Canones Ecclesiastici and Bishop Serapion's Prayer Book to be used with the application of holy oil to heal those with fever, sickness, or those possessed by demons, and both sacramental healing and exorcism were mentioned in other sacred writings as early as the mid-second century.[9] Origen (185—254 CE) was particularly influential in forming early Christian thinking about mental illness and demonology."[10]

As language and understanding of mental health began to grow, the terms of "possession" and "insanity" began to be used. "In De Principiis he articulated his belief that demons could completely take over the mind, removing the power of reason and emotional control. He used the terms "possession" and "insanity" as referring to similar states, and emphasized that Jesus healed the insane by exorcism—the casting out of

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[7] Amy Simpson, *Troubled Minds: Mental Illness and the Church's Mission* (Downers Grove, IL: IVP Books, 2003), 136.

[8] Koenig, *Faith and Mental Health,* 18-19.

[9] R. L. Numbers and D. W. Amundsen, *Caring and Cursing: Health and Medicine in the Western Traditions* (Baltimore, MD: John Hopkins University Press, 1998), 51.

[10] Koenig, *Faith and Mental Health,* 18-19.

demonic spirits."[11] This change in the perspective and language may have contributed to later the mistreatment of persons suffering from mental illness which caused mental health persons to be avoided and rejected from society.

During the beginning of the classical Greek, medicine began to emerge as an art distinct from religion in classical Greece to attributed to natural human causes.[12] This shift from the priest and religious leadership to a more medicine mindedness in dealing with mental health was significant with the growth of medicine. One would imagine that the church began to then become skeptical of the art of medicine. A result of the spiritual shift from a religious nature to the art of medicine, it left many persons without proper treatment or concern for the mentally ill. The art of medicine had a different treatment and perspective in treating the mentally ill.

History of Mental Health Care

Historically, the mission of the church is to care for the sick and the poor which comes from the Jewish tradition. "The establishment of large hospitals for care of the sick in the general population, according to historians Sarton,[13] Granshaw,[14] and Porter,[15] was a Christian notion that developed in the fourth century."[16]

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[11] Koenig, *Faith and Mental Health*, 17-18.

[12] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

[13] G. Sarton, *Introduction to the History of Science* (Baltimore, MD: Williams and Wilkins, 1931), 245.

[14] L. Granshaw, *The Hospital: In Companion Encyclopedia of the History of Medicine*, ed. W. F. Bymun and R. Porter (New York, NY: Routledge, Chapman and Hall, Inc., 1993).

[15] R. Porter, *Greatest Benefit to Mankind: A Medical History of Humanity* (New York, NY: WW Norton and Co., 1997), 88.

[16] Koenig, *Faith and Mental Health*, 18.

These historians were "inspired by biblical teachings to clothe the poor and heal the sick, Christians extended the long-held Jewish tradition of care for the sick."[17] Outreaches begin to develop to help the ill and the poor after Christianity became the major religion of the Roman Empire. Koenig states "By 250 CE, the Christian church in Rome had developed an outreach to the poor and ill of all faith backgrounds, including the mentally ill. When Constantine declared Christianity the official religion of the Roman Empire, this charity "found expression in bricks and mortar."[18]

Further developments happened in Europe as hospitals developed to support the persons that were sick and experience mental illness.

> Between 344 and 358, the bishop of Antioch set up several hostels. In 360, the bishop of Sebasteia built a poor house. In 372, the bishop of Caesarea (in present-day Turkey) established the first great hospital, called Basileias, described as "almost a new city" for the treatment of the sick, the poor, and those with leprosy. This hospital had both nurses and medical attendants. Hostels, poor houses, and these early hospitals often addressed the mental health needs of patients right alongside their physical needs.[19]

Further buildings as sickness began to be associated with being mentally ill.

Koenig states, "Soon, the Christian church began building hospitals throughout West-ern Europe." Around 390 a facility was built in Rome to care for the sick poor. These Christians "personally tended the unhappy and impoverished victims of hunger and disease . . . washing wounds which others . . . could hardly bear to look at . . . gathered sufferers from the streets . . . carried home, on [their] own shoulders, the dirty and poor who were plagued by epilepsy! [or mental illness, which epilepsy was often

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[17] Koenig, *Faith and Mental Health*, 19.

[18] Koenig, *Faith and Mental Health*, 19.

[19] Koenig, *Faith and Mental Health*, 19.

confused with] . . . washed the pus from sores which others could not even behold. Comparing these activities with attitudes in the surrounding populace, historian Roy Porter remarks, "Greek and Roman paganism had acknowledged no such duties."[20] Numbers and Amundsen also note, "In general there was no religious or ethical motivation for charity in the pagan classical world. Among the Greeks and Romans, benevolence manifested itself in civic philanthropy on behalf of the entire community rather than in private charity undertaken for individuals in need, such as the sick, widows, or orphans."[21]

Middle Ages

Koenig states:

> The Middle Ages covers the period between around 500 and 1500 CE. By the fifth century, there were clear records of the Christian church helping, the mentally ill. One of the first hospitals devoted to treating those with mental illness was established in Jerusalem in 490. In the sixth century, the mentally ill were cared for in monasteries run by the Christian church, although these tended to focus on the care of their own members.[22]

Later writing began to discuss in layperson's terms and not in mystical terms. Koenig states, "Between 1215 and 1230, a Franciscan monk and professor of theology named Bartholomaeus wrote an encyclopedia that dealt with mental illness in terms of natural causes, not supernatural ones."[23]

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[20] Koenig, *Faith and Mental Health*, 19.

[21] Numbers and Amundsen, *Caring and Curing*, 48.

[22] Koenig, *Faith and Mental Health*, 19.

[23] Koenig, *Faith and Mental Health*, 20.

Europe's first establishment of a psychiatric facility began to emerge during the twelve century which began to advance the work of mental illness. This also showed the mistreatment of patients within the walls of these institutions.

> In 1247, Europe's first psychiatric hospital, the Priory of St. Mary of Bethlehem, was established in London on the Thames River. It was originally designed to house "distracted people." Three centuries later in 1547, after the land of the priory was given to the city of London, St. Mary's was torn down and replaced by Bethlehem or Bethlem Hospital. The common name for the hospital was "Bedlam," which became famous for its inhumane treatment. Patients were often chained to walls and dunked in water or beaten if they misbehaved. The hospital housed about sixty patients at a time. In 1676 a new hospital was built on the original site. Larger and more modern, it held about 150 patients. Bedlam soon became a popular tourist attraction, since people from London often came to observe and be entertained by the patients. The admission in 1753 was two pence. This was such a lucrative venture for the hospital that they continued to "show" patients until the end of the eighteenth century.[24]

"In 1409, another religious-sponsored hospital in Europe was built specifically to care for the mentally ill. It was established in Valencia, Spain, directed by a priest, and both supported and operated by a religious order of brothers."[25] The treatment of the mentally ill caused many persons to develop places for the mental ill to live without being in these abusive institutions. "Mentally ill persons were also admitted to the Hotel-Dieu (Hospital of God) in Paris, the largest hospital in Europe and the center of medical training throughout the Middle Ages."[26] "A common treatment at the Hotel-Dieu was to arrange for the insane to be taken to various healing shrines in the area (including the Dymphna shrine at Gheel), since there were no other treatments."[27]

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[24] Koenig, *Faith and Mental Health*, 20.

[25] Koenig, *Faith and Mental Health*, 19.

[26] J. Kroll, "A Reappraisal of Psychiatry in the Middle Ages," *Archives of General Psychiatry* 29, no. 2 (1973): 276-283.

[27] Koenig, *Faith and Mental Health*, 20.

Religious care began to emerge for persons that were mentally ill. "The care provided in religious-sponsored hospitals like these, administered under the direction of priests and sisters, was reported to be much better than that provided by state—supported mental asylums centuries later."[28] Historically, the Christian church struggled with the compassion and love toward the mentally ill at large instead the church was still trying to understand mental illness as demon possession and only a "spirit" possession and not an illness. Koenig states:

> The Christian church, however, did not always behave compassionately toward the mentally ill. A common explanation in the general population was that mental illness was due to demonic possession, which led to persecution of the insane (whose numbers in Europe increased dramatically after 1300). However, historical evidence suggests that the role of the church in persecuting the so-called demon-possessed has been widely exaggerated.[29]

The Christian church continued to struggle with how to care and support the mentally ill and their place in the religious community. A misunderstanding of the mentally ill caused major tensions as the church as the Christian church continued to continue to hold on the belief of demoniac possession of the mentally ill. Koenig states:

> The Inquisition, established in 1233, was an institution in the Christian church whose purpose was to eradicate heresies, not combat witchcraft or demon-possession, which was of secondary interest only. Not until I487, with the publication of *Malleus Maleficarum* that describes the diagnosis and treatment of those thought to be demon-possessed, did the Christian church's persecution of sorcerers and witches (and sometimes the mentally ill) become widespread.[30]

The treatment of the mentally ill still shows a great misunderstanding of that time which added the mistreatment of the mentally ill during this century, unfortunately, torturing

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[28] Koenig, *Faith and Mental Health*, 21.

[29] Koenig, *Faith and Mental Health*, 20.

[30] Koenig, *Faith and Mental Health*, 20.

and causing more trauma and pain for the mentally ill. "Prior to that time, natural and folk remedies were used extensively for the treatment of mental and what were considered "spiritual" illnesses."[31] "After that, torturing and burning "the possessed" became a more regular occurrence. This continued for nearly two hundred years with thousands of persons being burned at the stake or decapitated. These murders show that that mental health and illness can be misunderstood in many communities and can cause innocent people their lives. The last witch-hunts in the United States occurred in Salem, Massachusetts, in 1692, with nearly one hundred persons accused and nineteen executed."[32]

As psychiatrist and historian Jerome Kroll points out, however, "mental and spiritual illnesses were attributed as much to overwork, overeating, and overindulgence in sexual activity as to climatic conditions, magic spells and demon possession."[33] Over time, sin became viewed less and less as the cause of mental illness. "A systematic review of persons diagnosed with mental illness reported during the Middle Ages indicates that writers of the day attributed sin as the cause for only 16% of cases."[34]

Suzanne Phillips from the department of psychology at Gordon College (Wenham, MA) also notes that:

> Present—day psychology reports an inaccurate history of the European witch-hunts as a history of cruelty toward people with mental disorders at the hands of the church. In actuality, people with mental illness were not believed to be witches, nor were they executed. Throughout the medieval period, people with mental illness were cared for by the church and by society more generally; this

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[31] Koenig, *Faith and Mental Health*, 20.

[32] Koenig, *Faith and Mental Health*, 21.

[33] Kroll, "A Reappraisal of Psychiatry," 276-283.

[34] Jerome Kroll and Bernard Bachrach, "Sin and Mental Illness in the Middle Ages," *Psychological Medicine* 14, no. 3 (1984): 507-514.

> care was rooted in a richly integrated "understanding of mental disorder as simultaneously biological, psychological, and spiritual in nature."[35]

Thus, historians disagree on the extent to which mentally ill persons were persecuted during this time. No doubt, such persecutions did occur to some extent and resulted in many deaths, but exactly how many and over what period of time remains controversial.

> With the spread of Christianity came a commitment (rooted) in the Jewish tradition) to care for the sick. In the fourth century, Christians established the first hospitals and cared for all types of illness, including mental illness. This sparked a contrast to the pagan culture around them, which felt no duty to care the sick. One of the first hospitals was established in Jerusalem in 490, and the church continued to care for people with mental illness.[36]

"As medicine began to emerge as an art distinct from religion in Classical Greece, mental illness was attributed to natural causes. Hippocrates and Galen both whom believed madness was an imbalance among bodily humors which affected the sufferer's brain, the naturalistic movement in medicine exercised influence during the Greco-Roman era."[37]

In most ancient cultures, madness was attributed to possession by supernatural spirits. Caregivers were usually priests or shaman-type religious functionaries who appeased the gods or exorcised demons. Torture was often a "treatment of choice," as epitomized by the practice in Neolithic cultures of drilling holes in the skull to allow evil spirits to escape (trepanation).

> With few exceptions, however, superstition and magic prevailed in the treatment of mental disorders during the Middle Ages. One development of note was the establishment of hospitals for the care of the insane in centers like Valencia in Spain, Gheel in Belgum and Bethlehem in London. During the 15th century, the infamous *Malleus Maleficarum* (The Witch's Hammer) linked witchcraft and mental illness. Within two centuries, this unfortunate confluence resulted in the

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[35] Suzanne Phillips, "Free to Speak: Clarifying the Legacy of the Witch Hunts," *Journal of Psychology and Christianity* 21, no. 1 (2002): 29-41.

[36] Simpson, *Troubled Minds*, 137.

[37] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

> torture and execution of perhaps two hundred thousand people demented persons in France and Germany.[38]

Many cultures have viewed mental illness as a form of religious punishment or demonic possession. In ancient Egyptian, Indian, Greek, and Roman writings, mental illness was categorized as a religious or personal problem. In the fifth century B.C., Hippocrates was a pioneer in treating mentally ill people with techniques not rooted in religion or superstition; instead, he focused on changing a mentally ill patient's environment or occupation, or administering certain substances as medications. During the Middle Ages, the mentally ill were believed to be possessed or in need of religion. Negative attitudes towards mental illness persisted into the eighteenth century in the United States, leading to stigmatization of mental illness, and unhygienic (and often degrading) confinement of mentally ill individuals.[39]

By the late Middle Ages, economic and political turmoil threatened the power of the Roman Catholic church. Between the eleventh and fifteenth centuries, supernatural theories of mental disorders again dominated Europe, fueled by natural disasters like plagues and famines that lay people interpreted as brought about by the devil. "Superstition, astrology, and alchemy took hold, and common treatments included prayer rites, relic touching, confessions, and atonement."[40] "Monasteries cared for some, while the first psychiatric hospital in Europe opened in London in 1247. This hospital, the

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[38] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

[39] "A Brief History of Mental Health in the United States," Unite for Sight, accessed October 17, 2016, www.uniteforsight.org.

[40] Ingrid G. Farreras, "History of Mental Illness," The BA Project, accessed October 21, 2016, www.nobaproject.com.

Priority of St, Mary of Bethlehem was later given to the city of London, torn down and replaced by the Bethlehem or Bedlam hospital, which continued through the 1700's."[41]

Renaissance and Reformation

During the Renaissance and Reformation period many changes occurred as it relates to rethinking and reshaping the church's view on religious and the treatment of mental health. "The Renaissance was the period in Europe beginning in the mid-1300s following the Black Death (which killed one-third of the population) and ended in 1517 with the Protestant Reformation, when Luther nailed his ninety-five theses on the church door at Wittenburg. The Reformation era lasted until the close of the eighteenth century."[42]

The work of psychiatrist and historian Samuel Thielman summarized the events that occurred during these periods.[43]

> Between the mid-fourteenth century and the end of the eighteenth century, ideas about mental illness in both the medical profession and the Christian church did not change much. These views oscillated back and forth between biological and spiritual causes. Both Catholics and Protestants believed that some mentally ill people were possessed by demons, even though others might simply have diseases of the brain. St. John of the Cross (1542—1591) described two types of depression in his book *Ascent of Mount Carmel*.[44]

"One type he thought was spiritual and described as the "dark night of the soul" that led to spiritual growth and deeper understanding. A second type, which he characterized as

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[41] Simpson, *Troubled Minds*, 137.

[42] Koenig, *Faith and Mental Health*, 21.

[43] S. B. Thielman, *Religion in the History of Psychiatry: Handbook of Religion and Mental Health* (San Diego, CA: Academic Press, 1998), 3-18.

[44] Koenig, *Faith and Mental Health*, 21.

melancholy, led to further despair and loss of hope. He instructed priests who took confessions to try to distinguish between these two conditions."[45]

The church continued to be plagued by the understanding of mental health as seen in the forms of depression during the Reformation Period. Further writing helped to voice the concern for the mentally ill and attention to positive attention mental health in terms of depression being a spiritual but a psychological concern.

"On the one hand, even well-known mental health professionals of the day attributed some kinds of depression to religious forces."[46] In his famous *The Anatomy of Melancholy*, Robert Burton described religious melancholy as being due to both natural and supernatural causes. On the other hand, religious professionals such as St. John of the Cross, who experienced depression, refuted arguments that demons caused depression, maintaining that those with melancholy should receive compassionate care and see doctors who might help ease their burdens.[47] Timothy Rogers emphasized in 1691 the need to "address the spiritual, medical, and psychological concerns in a balanced fashion:" ". . . it is a very overwhelming thing to attribute every action almost of a Melancholy man to the Devil, when there are some unavoidable Expressions of sorrow which are purely natural, and which he cannot help."[48]

During the late seventeenth and eighteenth centuries, as the scientific revolution gained momentum, references in the medical literature to demons as a cause for mental

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[45] E. A. Peers, *Ascent of Mount Carmel* (Garden City, NJ: Image Books, 1962).

[46] Koenig, *Faith and Mental Health*, 21.

[47] R. Hunter and I. McAlpine, eds., *Three Hundred Years of Psychiatry 1535-1860* (London, UK: Oxford University Press, 1963).

[48] Hunter and McAlpine, *Three Hundred Years of Psychiatry*, 26.

illness became less and less common. "Physician, George Cheyne argued forcefully in his 1733 publication, *The English Malady*, against the notion that mental disorders were caused by witchcraft or possession, using his own case of mental illness to illustrate his points." [49] "As a religious person, he described both the comforts of religious faith and the religious preoccupations that created turmoil and anxiety."[50] "The fact that many well-known religious men throughout the Renaissance and Reformation periods experienced severe bouts of depression, including Martin Luther himself,"[51] "helped to discredit the notion that demonic possession or a weak religious faith was at the root of melancholic or neurotic disorders."[52]

The Age of Reason and Enlightenment

The Enlightenment period changed the course of mental health from just being a spiritual issue but to a spiritual, psychological and medical issue. During the era, people began to take a different look at mental health and provide scientific understanding to many of the beliefs of mental health being a manner of demon possession. There was the establishment of the asylums and further mistreatment of the mentally ill.

Koenig states:

> The Age of Reason followed soon after the Reformation era and was characterized by a decline in tolerance for religious beliefs. This period culminated with the arrival of the Enlightenment in 1800, as the French Revolution came to a close. The appearance of nonreligious explanations for

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[49] G. Cheyne, *The English Malady: Or a Treatise of Nervous Diseases of all Kinds* (London, UK: G. Strahan and J. Leake, 1735), 34.

[50] Koenig, *Faith and Mental Health*, 22-23.

[51] M. Brecht and J. L. Schaaff, *His Road to Reformation, 1483-1521* (Minneapolis, MN: Augsburg-Fortress, 1993).

[52] Koenig, *Faith and Mental Health*, 22-23.

> mental disorders increased rapidly, as scientific explanations were sought for these conditions and all other illnesses. Since there were still no proven treatments for mental disorder, attention turned to asylum reform. Indeed, there was much to reform.[53]

History shows that mistreatment of person in the asylums as such viewed on a horror movie. "London's Bethlem Hospital (Bedlam) is a case in point. To this day, books and horror movies display the cruelty and neglect, the whips and chains used to control and dehumanize the mentally ill."[54]

Consider the description below:

> A stout iron ring was riveted around his neck, from which a short chain passed through a ring made to slide upwards and downwards on an upright massive iron ban more than six feet high, inserted into the wall. Round his body a strong iron bar about two inches wide was riveted; on each side of the bar was a circular projection; which being fastened to and enclosing each of his arms, pinioned them close to his sides.[55]

The treatment of the person in the asylums begin to draw attention to changing the way that patients were treated in these institutions.[56] People begin to question the of moral and ethical treatment of persons with mentally ill in these institutions. Koenig notes:

> The new asylums of the nineteenth century tried to eliminate such abuses. The French physician Philippe Pinel, a religious man who had at one point planned to become a priest, was made head of an asylum in France in 1793. Upset by the way that patients were being cared for there, he tried releasing them from their restraints and treating them with compassion. To everyone's amazement, this action met with great success, especially for those suffering from melancholia (depression) or mania.[57]

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[53] Koenig, *Faith and Mental Health*, 23.

[54] Koenig, *Faith and Mental Health*, 23.

[55] R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York, NY: W. W. Norton and Company, 1997), 497.

[56] Koening, *Faith and Mental Health*, 23.

[57] Koenig, *Faith and Mental Health*, 23.

Pinel states and emphasized " ....that mental illnesses were influenced by psychological and social factors as well as by physical causes, and therefore needed psychological treatments. He called his new method traitement moral or "moral treatment," which emphasized kindness and "ways of gentleness. The idea that mental illness might be curable using this new form of treatment spread quickly across Europe."[58]

The Reformation period brought reformation of the treatment of the mentally ill as a social and moral issue. "……to the reformation of asylums and the development of more humane methods of managing mental patients. Restraining with chains and beatings were soon done away with."[59]

Further development of the treatment of the mentally ill from the English and the Quaker community help to further challenge the treatment of persons in the asylums. As growing concern for the treatment of the mentally ill began to the a moral and justice issue, measures and laws begin to be put in place to help the mentally ill such as creating safer asylums rather than restraints and isolating patients.

Koenig notes:

> At almost the same time, another form of moral treatment was being developed in England independent of what was happening in France. An English merchant and devout Quaker named William Tuke established the York Retreat in 1796. He was motivated by the death of a Quaker patient in a New York asylum due to abuses that were still common there. As a result, Tuke and the Quaker community decided to set up their own asylum. Rather than restraining and isolating patients, treatment involved intelligent and humane care. At the York Retreat they instituted a regimen of exercise, work, and recreation, treating the insane with compassion. Tuke saw the mentally ill as brothers capable of living a moral, ordered existence if treated with kindness, dignity, and respect in a comfortable setting. As a result, patients lived, worked, and had their meals together in a family-like atmosphere. The goal was restoration of self-control. The Quakers argued, as Pinel had in France, that insanity was a disruption of the

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[58] Koenig, *Faith and Mental Health*, 21.

[59] Koenig, *Faith and Mental Health*, 24.

> mind and spirit, not just the body. Tuke testified before English Parliament in 1815, contrasting the "hell" like atmosphere of Bedlam with the "heaven" like setting at the York Retreat. Soon moral treatment was adopted throughout England.[60]

Origins of American Psychiatry

American Psychiatry had a major influence on the treatment of the mentally ill. There has always been a division between medicine, science and the religious community in the treatment and understanding of the mentally ill. The movement saw a shift in the way that the church viewed the mentally ill as they were established of the first private institution in the United States for the mentally ill.

Koenig notes:

> Early American psychiatry was heavily influenced by developments in England at the time. The Quakers brought moral treatment to America in the early 1800s and this soon became the dominant form of psychiatric care in the United States. Friends Hospital (or Friends Asylum), established in Philadelphia in 1813, became the nation's first private institution dedicated solely to the care of those with mental illness. In 1818, the McClean Hospital was established in Boston; in 1821, the Bloomingdale Asylum in New York; and in 1824, the Hartford Retreat in Connecticut—all modeled after the York Retreat in England and implementing moral treatment as the dominant therapy.[61]

Psychologist Albert Ellis, the founder of rational emotive therapy forerunner of cognitive-behavioral therapy,[62] also emphasized that:

> Devout, orthodox, or dogmatic religion (or what might be called religiosity is significantly correlated with emotional disturbance. . . . The emotionally healthy individual is flexible, open, tolerant, and changing, and the devoutly religious person tends to be inflexible, closed, intolerant, and unchanging. Religiosity,

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[60] Koenig, *Faith and Mental Health*, 24.

[61] Koenig, *Faith and Mental Health*, 24-25.

[62] Koenig, *Faith and Mental Health*, 27

> therefore, is in many respects equivalent to irrational thinking and emotional disturbance.[63]
>
> By the close of the twentieth century, the negative attitude toward religion expressed by Freud and more contemporary mental health professionals such as Watters and Ellis had impacted the personal views of many practicing psychologists and psychiatrists. Surveys in the 1980s and I990s found that 57% to 74% of psychologists" and 2.4% to 75% of psychiatrists did not believe in God, compared to only 4% of nonbelievers in the general U.S. population.[64]

Psychiatrists in England were even less likely than those in the United States to have religious beliefs. Neeleman and King studied 231 psychiatrists at general and psychiatric hospitals in London. Investigators found that 73% of psychiatrists reported no religious affiliation and 78% attended religious services less than once a month. Among female psychiatrists, 39% believed in God, whereas only 19% of male psychiatrists did so. Although over 90% believed that religion and mental illness were connected and that religious issues should be addressed in treatment, 58% of psychiatrists in that survey never made referrals to clergy.[65]

"The gap between mental health professionals' personal religious beliefs and the beliefs of their patients no doubt affected the kinds of treatments prescribed."[66] Larson and Thielman et al note:

> In fact, until 1994 the Diagnostic and Statistical Manual of Mental Disorders (DSM) commonly used religious examples to illustrate serious cases of mental illness that included illogical thinking, incoherence, poverty of content and speech, poverty of affect, catatonic posturing, delusions of being controlled, hallucinations, magical thinking, and psychotic delusions. A systematic review of

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[63] Koenig, *Faith and Mental Health*, 27.

[64] Princeton Religion Research Center, *Religion in America: Will the Vitality of the Church Be the Surprise of the 21st Century?* (Princeton, NJ: The Gallop Poll, 1996), 22.

[65] Koenig, *Faith and Mental Health*, 27.

[66] D. B. Larson et al., "Religious Content in the DSM-III-R Glossary of Technical Terms," *American Journal of Psychiatry* 150, no. 12 (1993): 1884-1885.

> the religious content of DSM-III-R found that over 2.2% of all cases of mental illness included religious descriptions.[67]

"Trainees graduating today from psychiatry residency programs, however, may be more informed about both the positive and the negative effects that patients' religious beliefs and practices may have on mental health."[68] "The American College of Graduate Medical Education now includes in its Special Requirements for Residency Training for Psychiatry that all programs provide training on religious or spiritual factors that influence psychological development."[69] At least the official word, then, is that psychiatrists should be aware of these issues. "Research suggests that recent graduates may be more open to discussing the religious or spiritual beliefs of patients. In a study of 96 psychiatric residents, 40% reported a substantial degree of religiosity [high belief (74%), high practice (50%), high priority (71%)],[70] and indicated that it was particularly important to know about the religious beliefs of psychotherapy patients."[71]

More recent studies of practicing psychologists also suggest changing attitudes toward religion, however many programs do not require any training in spirituality or religious issues. "It is still true that many psychologists and psychiatrists in the United States still do not inquire about the religious or spiritual beliefs of patients, and it is even

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[67] Larson et al., "Religious Content," 1884-1885.

[68] Koenig, *Faith and Mental Health*, 28.

[69] Accreditation Council on Graduate Medical Education, *Special Requirements for Residency Training Programs in Psychiatry* (Chicago, IL: Accreditation Council on Graduate Medical Education, 1994).

[70] Accreditation Council on Graduate Medical Education, *Special Requirements.*

[71] Accreditation Council on Graduate Medical Education, *Special Requirements.*

less common for them to address spiritual needs or utilize the spiritual resources of patients as part of therapy."[72]

History of Mental Health Care in America

Insane asylums in early and mid-nineteenth-century America, then, involved a mixture of science and religion.[73] "Patients in some institution were rewarded for self-control and good behavior by allowing them to attend religious services."[74] According to Amariah Brigham, the superintendent at the Hartford Retreat and founding editor of the *American Journal of Insanity* (later to become the *American Journal of Psychiatry*), "No doubt that these services are beneficial to our patients. Permission to attend them is solicited by nearly all and many are induced to exercise their self-control in order to enjoy this privilege."[75] Even Samuel Woodward, superintendent of the Worcester State Hospital in Massachusetts and founder of the Association of Medical Superintendents of American Institutions for the Insane (later to become the American Psychiatric Association), observed, "Clergy were routinely hired to live on the grounds of these early psychiatric hospitals, both holding religious services and providing spiritual counsel.[76]

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[72] Koenig, *Faith and Mental Health*, 27-28.

[73] L. Gamwell and N. Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (New York, NY: University of New York at Binghamton and Cornell University Press, 1995).

[74] T. Taubes, "Healthy Avenues of the Mind: Psychological Theory Building and the Influence of Religion During the Era of Moral Treatment," *American Journal of Psychiatry* 155, no. 8 (1998): 1001-1008.

[75] T. Taubes, *The 17th Annual Report of the Officers of the Retreat Before the Insane at Hartford* (Harford, CT: Tiffany and Burnham Printers, 1841), 24.

[76] Taubes, "Healthy Avenues of the Mind," 1001.

Koenig notes that leaders such as "Dorothea Dix championed the cause for humane care of the mentally ill in America and Europe." [77] Her efforts brought social and moral reforms. As more medical discoveries occurred during this time, social and moral reform helped to provide better treatment for the mentally ill. Koenig states:

> It was not until the eighteenth century, Enlightenment that medicine as a whole and the treatment insanity in particular became stripped of supernaturalism and infused with the spirit of scientific inquiry. The mentally ill then became wards of the state and their treatment placed in the hands of physicians. Under such leaders as Pinel, Tuke, and Chiarugi, treatments became increasingly humane and optimistic in terms of outcome. Many new hospitals for the insane was built in Europe and American during the 1800s.[78]

Theses noted leaders were people of faith that pushed of better treatment of the mentally ill. Koenig notes:

> Thus, those who crusaded for better treatment of the mentally ill and asylum reform were often people of faith: Philippe Pinel, William Tuke, and Dorothea Dix. The close relationship between religion and psychiatry, however, was to change dramatically over a period of little more than fifty years. Sigmund Freud would have an enormous influence on psychiatry's attitude toward religion and lead to a near complete separation of the two within a few decades.[79]

Sigmund Freud challenged the church's beliefs on the views and treatment on the mentally ill which created a major separation between religion and psychiatry.[80] Bogia notes:

> Early mental health hospitals had no need for separate for chaplaincy services, since the whole approach to treatment was dominated by religious oriented persons. For example, in America, the Quakers were largely instrumental in the establishment of the Pennsylvania Hospital in 1792. Although chaplains had been

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[77] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

[78] Aist, *Dictionary of Pastoral Care and Counseling*, 711.

[79] Koenig, *Faith and Mental Health*, 25-26.

[80] Koenig, *Faith and Mental Health*, 26.

> familiar figures in the military services and in some other institutions, it was not until the early 1900's that the concept was applied to mental hospitals.[81]

The development of chaplaincy and clinical pastoral education help seminarian students connect their religious beliefs and clinical training in hospital especially in psychiatric hospitals. The life of Anton Boisen, known as the father of clinical pastoral education helped to change the course and the use of clinically trained ministers within psychiatric and other hospitals in order to care for the mentally and psychically challenged patients. Bogia notes:

> In 1924, the Rev. Anton Boisen became a full-time chaplain at Worcester State Hospital, Worcester, Massachusetts. Boisen was a minister with a troubled history, having been hospitalized himself for mental difficulties. During his hospitalization, he became convinced that he had a breakthrough in the walls between medicine and religion, and dedicated the rest of his life to developing this concept. In doing so, he laid the groundwork for specialized training for chaplains and emphasized the contributions which may be made to medicine by theology.[82]

Modern Times

Historically, there has always been tension between religion, the church and the psychiatric community. Many psychologists stated their feelings about religion being a hindrance to the growth of development. "Freud described religion as an "obsessional neurosis"[83] based on illusion and projection."[84] In *Future of an Illusion*, Freud wrote:

> Religion would thus be the universal obsessional neurosis of humanity. . . . If this view is right, it is to be supposed that a turning-away from religion is bound to occur with the fatal inevitability of a process of growth. . . . If, on the one hand,

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[81] B. P. Bogia, *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abingdon Press, 2005), 718.

[82] Bogia, *Dictionary of Pastoral Care and Counseling*, 716-717.

[83] Sigmund Freud, *The Future of an Illusion* (Blacksburg, VA: Wilder Publications, 2010), 43.

[84] Koenig, *Faith and Mental Health*, 26.

> religion" brings with it obsessional restrictions, exactly as an individual obsessional neurosis does, on the other hand it comprises a system of wishful illusions together with a disavowal of reality, such as we find in an isolated from nowhere else but amentia, in a state of blissful hallucinatory confusion.[85]

> By 1980, psychiatric wards at a number of prominent academic teaching hospitals in the United States had completely removed any religious influences from the treatment of psychiatric patients. Even at Methodist-affiliated institutions such Duke University and its adjoining hospital, the attending physician on the psychiatry ward had to explicitly authorize a visit by a clergyperson or even by a hospital chaplain. Psychiatrists and psychologists often interpreted religious beliefs as emotionally disturbing and harmful for patients.[86]

Professor of psychiatry Wendell Watters at McMaster's University said it this way:

> Evidence that religion is not only irrelevant but actually harmful to human beings should be of interest, not only to other behavioral scientists, but to anyone who finds it difficult to live an unexamined life. Finally, the argument advanced in this volume should stir the political decision makers who complain about the high cost of health care even while continuing to subsidize that very institution that may be actually making the public sick.[87]

Mental Health in the Twentieth Century

Mental Health America (MHA), originally founded by Clifford Beers in 1909 as the National Committee for Mental Hygiene, works to improve the lives of the mentally ill in the United States through research and lobbying efforts. A number of governmental initiatives have also helped improve the U.S. mental healthcare system. In 1946, Harry Truman passed the National Mental Health Act, which created the National Institute of Mental Health and allocated government funds towards research into the causes of and treatments for mental illness. In 1963, Congress passed the Mental Retardation Facilities and Community Health Centers Construction Act, which provided federal funding for the development of community-based mental health services. The National Alliance for the Mentally Ill was founded in 1979 to provide support, education, advocacy, and research services for people with serious psychiatric illnesses. Other government

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[85] Freud, *The Future of an Illusion*, 43.

[86] Koenig, *Faith and Mental Health*, 26.

[87] Wendall Watters, *Deadly Doctrine: Health, Illness, and Christian God-Talk* (Buffalo, NY: Prometheus Books, 1992), 12.

> interventions and programs, including social welfare programs, have worked to improve mental health care access.[88]

Until the early nineteenth century, psychiatry and religion were closely connected. Religious institutions were responsible for the care of the mentally ill. A major change occurred when Charcot[89] and his pupil Freud associated religion with hysteria and neurosis. This created a divide between religion and mental health care, which has continued until recently. Psychiatry has a long tradition of dismissing and attacking religious experience. Religion has often been seen by mental health professionals in Western societies as irrational, outdated, and dependency forming and has been viewed to result in emotional instability.[90]

Mental Health and "New Thought Church Movement"

In the later nineteenth century, what have been called the "New Thought," Mind-cure, and Harmonial religious movements had considerable influence within the Protestant churches, and they also lead to the formation of a number of new religious bodies.[91] Christian Science began to be established by Mary Baker Eddy lead to the discovery of how to be in good health and how to cure others. In 1889, the Unity School of Christianity was founded in Kansas City, Missouri by Charles and Myrtle Fillmore

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[88] "Timeline: Treatments for Mental Illness," PBS Online, accessed October 16, 2017, www.uniteforsight.org.

[89] J. M. Charcot, "Leçon D'ouverture," *Progrès Médical* 10 (1882): 336.

[90] D. Crossley, "Religious Experience within Mental Illness: Opening the Door on Research," *British Journal of Psychiatry* 166, no. 3 (1995): 284-286.

[91] Sydney E. Ahlstom, *A Religious History of the American People*, vol. 2 (Garden City, NJ: Yale University, 1975), 528-548.

seeking to deepen the life of prayer and its healing efficacy in the churches and the larger society.[92]

Conclusion

The history of mental health is foundational to the anticipated doctoral project. The church at large has played a major role in the development of the mental health movement historically. Mental health historically, has evolved and ignored as it moved from the primitive days of a shaman doing work in the spiritual and underworld to the mentally challenged being exploited in institutions of asylums then to hospital and community-based services for the mentally ill.

There has been major tension between the world of religion and theology historically and the world of science and psychiatry. The church has had a controversial challenge with their response to their treatment of the mentally ill throughout its history has deep roots in social and moral responsibility of the church.

"During the Middle Ages to present day, mental illness been treated by the church better than institutions in many places however the theology of demonology and demon possession continue to change the treatment of the mentally ill as being part of witchcraft. In many cases witchcraft serves as attach against people's belief in God and therefore caused many persons to be treated unfairly by the church as seen in the Salem Witch Trails.[93]

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[92] Williston Walker et al., *A History of the Christian Church*, 4th ed. (New York, NY: Simon and Schuster, 1985), 664-665.

[93] Koenig, *Faith and Mental Health*, 20.

"The church's history shows to its leaders suffering from possible depression, church's leaders such as "St. John of the Cross, Timothy Rogers and Martin Luther, who themselves indicated in their writings that they suffered from common symptoms of depression."[94] Therefore there seems to still be a battle within the church and its community for fair treatment and compassion of the mentally ill or person's experiencing mental breakdown. Will the church take on the mission like Dorothea Dix and lobby for better treatment for the mentally ill and mental health? Will the church leave persons in isolated systems or in the dangerous communities? Koenig stated:

> In the 1840s, activist Dorothea Dix lobbied for better living conditions for the mentally ill after witnessing the dangerous and unhealthy conditions in which many patients lived." Over a 40-year period, Dix successfully persuaded the U.S. government to fund the building of 32 state psychiatric hospitals.[95]
> "Deinstitutionalization efforts have reflected a largely international movement to reform the "asylum-based" mental health care system and move toward community-oriented care, based on the belief that psychiatric patients would have a higher quality of life if treated in their communities rather than in "large, undifferentiated, and isolated mental hospitals."[96]

What is the role of the church in the twenty-first century concerning the mentally ill and mental health. Will the church continue to turn away from communities that are often marginalized and misunderstood or will the church incorporate mental health as part of the church's mission of healing and spiritual care for wounded?

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[94] Simpson, *Troubled Minds*, 137.

[95] "Timeline: Treatments for Mental Illness," PBS Online, accessed October 20, 2017, www.uniteforsight.org

[96] E. J. Novella, "Mental Health Care and the Politics of Inclusion: A Social Systems Account of Psychiatric Deinstitutionalization," *Theoretical Medicine and Bioethics* 31, no. 6 (2010): 411-427.

CHAPTER FOUR

THEOLOGICAL FOUNDATIONS

Using the foundational goals of process, black liberation theory and pastoral theology, we find that a theology for mental health emerges. A theology of mental health and illness states that God is concerned about our mental health. This theology states that God cares about the "mind, body and spiritual health" of each of his children. God always cares and provides for God's people. All of us are "created in the image of God" and there needs to be an expansion of pastoral care to include mental health providers in terms of God caring for his people. The theological theme is of love and pastoral care through mental health, a theology of liberation and transformation, and a theology of wellness.

Theology of Love and Pastoral Care through Mental Health

In developing a theology of mental health, we must consider that God's love for humankind is foundational to all. God is concerned about our mental health. Practical theologian John Swinton states, "Mental health problems are unique experiences that occur in the lives of irreplaceable individuals who have their own unique stories, histories, dreams, and desires; people who are deeply loved by God, and whom God

desires God's church to love with boundaries. People's stories may be changed by their encounter with mental health problems but they are not defined by them."[1]

God's is concerned about all the experiences in the lives of God's people including our mental health issues and challenges. Swinton states, "The mental health industry is a big and hugely complex entity. In the midst of the high-tech neurological, genetic, and pharmaceutical landscape, it is easy for religious communities to feel nervous and disempowered. What could we possibility offer that might bring healing in the midst of such approaches mental health care?"[2] A theology of mental health brings an answer to this challenging question. A theology of mental health is theology of love and healing for the mind, body and the spirit which its foundation is the love of God for us.

The love of God calls us to have love and to give love to each other. Jean Vanier describe this extraordinary love as, "We are called to do, not extraordinary things, but very ordinary things, with an extraordinary love that flows from the heart of God."[3] Practical theologian, John Swinton describes the role of the church being "called to do ordinary things with extraordinary love" concerning mental health. Swinton further describes the church as a "community of disciples who strive to embody and reveal God's extraordinary love."[4] Swinton continues his development of practical theology in terms of the church showing love through time, hospitality and belonging. This theology

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[1] John Swinton, "Time, Hospitality, and Belonging: Toward a Practical Theology of Mental Health," *Word and World* 35, no. 2 (Spring 2015): 171.

[2] Swinton, "Time, Hospitality, and Belonging," 171.

[3] Jean Vanier, *Community and Growth* (Mahwah, NJ: Paulist, 1989), 298.

[4] Swinton, "Time, Hospitality, and Belonging," 171-172.

becomes the heart of the gospel of extraordinary love concerning the church and mental health.[5] Swinton further suggest a rethinking of the church working with persons with mental health problems in terms of reflecting on the nature and the work of Christian hospitality.[6] He states:

> Rather than assuming that the church's task is to host people with mental health problems-somehow to seek to find ways of looking after them because they can't look after themselves – we are called to ask what it might look like of our congregations were to become truly hospitable and began to think of themselves both in terms of guest and host in the presence of people experiencing mental health difficulties. In other words, instead of simply thinking we need to make room for people with mental health problems in order that we can care for them, the hospitable calling of the church is to learn to understand the stories of mental health and ill-health and to open itself to being a guest rather than simply a host.[7]

John Swinton states that there must be a "shift in the margin" as the church theologically reflects on the mission of God through Jesus as he simply, gifted time, presence, space patience and friendship to the stranger and the stigmatized. "This rational space and time to people for whom the world had no time, in and through friendships, he gave people back their names." [8]We are called by God though the example of Jesus as he made time, patience and friendship to the stranger and the stigmatized as seen the ministry of Jesus. Our "mission is to love people, respect their stories and to learn to call them by their name."[9] "The church must make room for friendships. Our call is to engage in the ordinary act of friendship with extraordinary love."[10]

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[5] Swinton, "Time, Hospitality, and Belonging," 171-172.

[6] Swinton, "Time, Hospitality, and Belonging," 177-178.

[7] Swinton, "Time, Hospitality, and Belonging," 177-178.

[8] Swinton, "Time, Hospitality, and Belonging," 177-178.

[9] Swinton, "Time, Hospitality, and Belonging," 180-181.

[10] Swinton, "Time, Hospitality, and Belonging," 180-181.

From a biblical perspective, God has always cared for the well-being and healing of God's people. For many centuries, there were no separation between a concern for religion and the concern for healing. Historically, the development of science was a method of human thought and investigation that resulted in the emerging of a separation between religion and social sciences.

> Until roughly a century ago, {1961} psychology, philosophy, and religion, in both the popular and academic mind, were essentially one discipline. But then, in an attempt to separate the empirical from the speculative, the scientific from the metaphysical, psychology and its medical counterpart, psychiatry, made a determined effort to establish themselves as separate enterprises.[11]

This section will show the following statements from a biblical perspective: (1) Mental health and wellness have always been a part of God's plan for the community and humanity; (2) In the Old Testament, the religious and spiritual leadership was integrated into the political system therefore there the religious and spiritual leadership was educated in both disciplines; (3) God has always used men and women to provide pastoral care in terms of guidance, counsel and healing to individuals and the community throughout the Bible; (4) Jesus provided a new meaning for pastoral care and mental wellness through his message for the community. Aquinas believed "that for the knowledge if any truth whatsoever man needs divine help, that the intellect may be moved by God to its act."[12] He believed that the intellect and human reasoning.

> Thomas defended the Augustinian-Franciscan (Platonic) tradition that all natural knowledge including the knowledge of God, therefore, is not self-evident: it is known immediately through reflection on the data of the experience, not immediately through the soul's probing of its own depths (Augustine-

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[11] O. Hobart Mower, *The Crisis in Psychiatry and Religion* (Princeton, NJ: D. Van Nostrand and Company, Inc., 1961), iv.

[12] Williston Walker et al., *A History of the Christian Church* (New York, NY: Scribner, 1985), 340-341.

> Bonaventura) or through the mind's possession of the very idea of God (Anslem).[13]

"Reason must be perfected by divine revelation contained in the canonical Scriptures."[14]

Mental health in terms of God caring and providing care for God's people is addressed in both Old and New Testaments as images and models of pastoral care. Both accounts address a common theme of healing being associated with mental health challenges. The healing ministry has been a part of the tradition and practices of the church, our ancestors were shamans, the prophets and seers who stood between humanity and God. Jesus later becomes the example of healing and was an intrinsic part of the communication of the presence of God. The church has been very ineffective in dealing with mental health within its congregation. When working with mental health in a congregation, we must examine it under the lens of pastoral care.

As we examine mental health in the biblical context, we must examine it under the lens of pastoral care. Biblical leaders provided pastoral care and "counsel" for God's people. There were three classes of biblical leadership in the Old Testament: priests, prophets and political leaders, which worked as ceremonial and political voices for Yahweh. These leaders became the moral compasses for the community for personal and moral conduct. Wise men and women gave counsel and moral guidance out of their wisdom a spiritual tradition under pastoral care.[15]

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[13] Walker et al., *A History of the Christian Church*, 340-341.

[14] Walker et al., *A History of the Christian Church*, 340-341.

[15] Charles V. Gerkin, *An Introduction to Pastoral Care* (Nashville, TN: Abington Press, 1997), 24-25.

In the New Testament, leaders such as scribes and rabbis were the dominant force of providing pastoral leadership and counsel for the people. The term "guidance" has been used in terms of "healing, reconciling and sustaining."[16] Charles Gerkin in his book, *An Introduction to Pastoral Care* discusses an interpretive structure of pastoral care and leadership in three primordial ancestral role models as there is a shift from the Old Testament to the New Testament. Gerkin states, "the prophets who spoke for the tradition and its concern for response to the voice of God, the priests who led the community in its cultic worship, the wise ones offered guidance to the people in the daily affairs of individuals and family life."[17] Charles Gerkin also suggests that these leaders provide the "ongoing care for the Christian tradition that grounds the faith and the practice of the life of the people."[18] These leaders also "attended to the life of the community of faith with care discernment" and "giving careful attention to the needs and problems of the individuals and families" in the community.[19]

These "prophetic, priestly and wisdom models of caring ministry" for God's people which helps to form and influence the biblical images of pastoral care in the modern century.[20] The model of the pastoral care as the "shepherd" Psalms 23 shows the "shepherding motif originated as a metaphor for the role of the king during the monarchial period of Israeliste history, it was never institutionalized as a designed role within the religious community, as were the prophetic, priestly, and wisdom roles. Jesus

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[16] Gerkin, *An Introduction to Pastoral Care*, 24-26.

[17] Gerkin, *An Introduction to Pastoral Care*, 26.

[18] Gerkin, *An Introduction to Pastoral Care*, 26.

[19] Gerkin, *An Introduction to Pastoral Care*, 26.

[20] Gerkin, *An Introduction to Pastoral Care*, 27.

latter identifies himself as the "good shepherd" as "the shepherding image takes place as a primary grounding image for ministry."[21] "From early Christianity to the present the images of pastoral leaders as the "shepherd of the flock" has persisted as a prototypical image applied to both pastors and ecclesiastical leaders of the institutional church.[22]

Mental health has been a part of the church and society from the very beginning of time. The church has always found ways to help people through many forms of pastoral care. Mental health has been a concern for the Christian church under the auspice of "pastoral care." Pastoral care has been a part of the Christian tradition and story for many centuries. Before Christianity, pastoral care was a significant aspect of the Israelite community and its tradition.[23] Pastoral care becomes a response to the human experience, which adapts to the changes of a culture and society.

"For many who seek psychiatric care, religion and spirituality significantly influence their internal and external lives and are an important part of healing."[24] "Because religion and spirituality often play a vital role in healing, people experiencing mental health concerns often turn first to a faith leader."[25] Unfortunately, clergy and congregations are not equipped to deal with the mental health issues among their congregations. Clergy play a major role in helping persons with mental health in their congregations. "In that role they (faith leaders) can help dispel misunderstandings,

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[21] Gerkin, *An Introduction to Pastoral Care*, 27

[22] Gerkin, *An Introduction to Pastoral Care*, 27.

[23] Gerkin, *An Introduction to Pastoral Care*, 23-24.

[24] "Mental Health: A Guide for Faith Leaders," American Psychiatric Association, accessed December 15, 2016, www.psychiatry.org.

[25] "Mental Health," accessed December 15, 2016, www.psychiatry.org.

reduce stigmas associated with mental illness and treatment, and facilitate access to treatment for those in need."[26]

A Theology of Pastoral Care for Mental Health

A theology of mental health develops also from a theology of pastoral care. A theology of pastoral care begins with a clear meaning of pastoral care. In the *Dictionary of Pastoral Care and Counseling,* Nancy Ramsey defines pastoral care using Rodney Hunter's definition of pastoral care as "theological informed ministry" that is "Grounded in a particular theological tradition, its goals are guided by the theological orientations of practitioners who are described as "representative religious persons"[27] not merely ordained persons-and communities of faith whose goals are nurture and support for persons and their "community relationships."[28]

Theologian John Patton states that the pastoral care is observed in three different perspectives: "proclamation, clinical pastoral and communal contextual."[29] He states that the function of these three perspectives "give attention to the faith perspectives offered, the person offering and receiving care, tbe context in which the care is offered, and the community authorizing the care."[30]

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[26] "Mental Health," accessed December 15, 2016, www.psychiatry.org.

[27] Rodney Hunter, *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abingdon Press, 1990), xii.

[28] Nancy Ramsay, *Pastoral Care and Counseling: Redefining the Paradigms* (Nashville, TN: Abingdon Press, 2004), 3.

[29] Ramsay, *Pastoral Care and Counseling*, 3.

[30] John Patton, *Pastoral Care in Context: An Introduction to Pastoral Care* (Louisville, KY: Westminster John Knox Press, 1993), 5-6.

These pastoral care perspectives become important in offering mental health support from a religious and spiritual perspective. Ramsay states "that Patton's schema calls attention to a shift in understanding care that reclaims it as a ministry of the church while also recognizing the importance of the context with its political, cultural, and embodied character."[31]

Ramsay further describes pastoral care as functioning separately from other forms of ministry but "has both restorative and transformative intent" in terms of "formation, support and advocacy."[32] The restoration, support and advocacy is part of the role of pastoral care in mental health. The spiritual and mental health provider supports persons from a spiritual and mental health perspective which becomes restorative and transformative for the person. The support then becomes a form of "healing, sustaining, guiding, and reconciling" as support is being offered. Pastoral Care theologians, Clebsch and Jackle describe this as "healing, sustaining and reconciling"[33] "are classic ways describing pastoral care as support in times of situational or developmental crisis for individuals and familie."[34]

A theology of pastoral care for mental health would involve being theological in the context of nurturing and supporting others in a community relationship and recognizes the context for which it serves. A theology of mental health using the insights

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[31] Ramsay, *Pastoral Care and Counseling*, 3.

[32] Ramsay, *Pastoral Care and Counseling*, 3.

[33] W. A. Clebsch and C. R. Jackle, *Pastoral Care in Historical Perspective* (New York, NY: Harper, 1967), 56-66.

[34] Ramsay, *Pastoral Care and Counseling*, 4.

from the religious experience through dialogue to produce a new theory or theology that becomes liberating, empowering and healing for all those who seek help.[35]

Theologian Christie Cozad Neuger discusses pastoral care in terms of pastoral theology and methodology as pastoral theology is a spiral image that "begins in particular and cultural experiences and then uses that experience both to critique and utilize the traditions and theories of pastoral theology."[36] Neuger further explains,

> Those traditions and theories include insights from Scripture, church traditions and doctrines, the social sciences, and clinical theories. From that dialogue between experiences, understood broadly, and the theory/theology, new and relevant pastoral practices are generated. Those practices are brought into the pastoral care and counseling process with the particular individuals and situations to see if they are, indeed, useful in offering, liberating, empowering, and healing directions for those seeking help.[37]

Anton Boisen, one of fathers of the clinical pastoral education movement says, "the minster of religion is concerned always with the problems relating to mental health." Boisen states, "The task of organized religion is to perpetuate and re-create religious faith."[38]

Doehring suggest that pastoral care givers must take a modern and post-modern approach in providing pastoral care. Doehring states, "a *modern* lens, pastoral draw upon rational and empirical methods, like biblical critical methods, medical knowledge, and

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[35] Ramsay, *Pastoral Care and Counseling*, 4.

[36] Ramsay, *Pastoral Care and Counseling*, 71.

[37] Ramsay, *Pastoral Care and Counseling*, 71.

[38] Anton Boisen, "Minister as Counselor," lecture given at University of Chicago on "Approaches to Human Adjustment," accessed November 12, 2016, *ATLA Religion Database with ATLASerials*, EBSCO*host*.

the social sciences, in offering pastoral care. A *postmodern* lens brings into focus the contextual and provisional nature of knowledge including knowledge of God.[39]

Black Liberation Theology

The lens of black liberation theology helps to shape the theological lens of African Americans church concerning mental health. First, theologian P.J. Paris, argues that "Black liberation theology represents of the religious dimension of a significant cultural revolution of that as forced by black Americans in the mid-sixties as a new development in their struggle for racial justice. Black liberation theology boldly asserts that a racist cultural bias in the Euro-American theological tradition has distorted the true meaning of Christianity."[40] Redefining this meaning from a mental health perspective requires one to have to reshape and redefine the meaning of self, others and our image of God mentally.

Secondly, black liberation theology speaks to mentally changing the mission of Jesus and helping people reshape their ideological assumptions of Jesus related to their experience. Theologian P.J. Paris hlack liberation takes a prophetic stance:

> Black theology wages the unrelenting battle against the ideological assumptions of ecclesiastical authorities and academic by advocating the identification of the mission of Jesus with the liberation struggles of oppressed peoples in general, and black American in particular. In fact, black liberation theology argues the solidary with the black American struggle is a fundamental requirement of all American Christians desirous of heing faithful to Jesus Christ.[41]

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[39] Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Louisville, KY: Westminster John Knox Press, 2006), 2.

[40] P. J. Paris, *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abingdon Press, 2005), 99.

[41] Paris, *Dictionary of Pastoral Care and Counseling*, 99.

Hillman states "Psychology does not take place without religion, because there is always a God in what we are doing."[42] God is always connected to all aspect of our human lives including our mental processes. Changing the mental image of Jesus Christ in a way on which African American people can see themselves as mental liberators.

Practical Theology

Another foundational part of a theology of mental health is founded in practical theology because it involves a theology that bring transformation of individuals and communities. Theologian David Polk states: "Practical theology arises at the confluence of theological reflection and ecclesial action. "Transformation" embraces not only individuals and their communities, but also the world around them."[43] Polk further explains practical theology "re-conceptualizes theology in a practical and relatable framework and becomes in important in shaping the faith of an individual and communities."[44] Polk continues by stating:

> Some scholars contend that all theology is practical. The current discussion recognizes that perspective and hails the shift of interest in present theological inquiry from the quest for universally valid constructs, abstracted from any particular socio-historical setting, to the clarifying of situation-specific expressions of faith and faithfulness. Feminist and Latin American liberation theologians are particularly at the forefront in this reorientation. But this development does not nullify the need for reconceptualizing the category of the theological enterprise traditionally identified as practical theology per se.[45]

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[42] James Hillman, *Re-visioning Psychology* (New York, NY: Harper and Row, 1975), 228.

[43] David P. Polk, *Handbook of Christian Theology* (Nashville, TN: Abingdon Press, 2003), 399-400.

[44] Polk, *Handbook of Christian Theology*, 399-400.

[45] Polk, *Handbook of Christian Theology*, 399-400.

Process theology is vital toward moving to the theology of mental health because it provides a framework for doing theology through the process of inquiry and usage of philosophical theology.

Polk states,

> The framework for most of the current reassessment was set in the early nineteenth century by Friedrich Schleiermacher, who characterized practical theology as the "crown" of an interrelated process of inquiry. Schleiermacher invoked the image of a tree to visualize the process: Philosophical theology constitutes the roots, historical theology (including biblical theology) composes the trunk, and practical theology the branches, leaves, and fruit. Schleiermacher emphasized the essential equality among these three dimensions of the theological task, and he worried that he would be mistakenly accused of subordinating the lower two activities to their more lofty partner. In fact, just the opposite occurred.[46]

Practical theology supports a theology of mental health because it sees pastoral theology as a part of theology as it seeks to establish legitimacy in the academic and contexts of the church. The church has not formed a theology of mental health and therefore have been ineffective in making theology practical and relevant in the life of the congregation. Pargament states, "Spirituality is not divorced from the psychological, social, and physical dimensions of life-far from it. The power of spirituality lies in the fact that it is fully embedded in the fabric of life."[47]

A theology of mental health is very similar to the tradition of "shepherding" as seen in the biblical images and theologies of pastoral care. Polk describes Theologian Seward Hiltner quest toward pastoral theology in terms of shepherding. [48] Polk states that

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[46] Polk, *Handbook of Christian Theology*, 399-400.

[47] Kenneth, I. Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred* (New York, NY, The Guilford Press, 2007), 21.

[48] Polk, *Handbook of Christian Theology*, 399-400.

theologian Seward Hiltner, "sought to unify the practical disciplines in American theological education around the task of Christian shepherding."[49] A theology of mental health supports the congregation in terms of "shepherding" and supporting the congregation from a holistic approach.

The role of a theology of mental health exists in the lives and life of a community of faith. This theology supports an understand and meaning of using a holistic approach in critical reasoning and creative action. This holistic approach as seen in practical theology is very important in understanding a theology of mental health. Polk further explains this holistic approach and praxis in the life of the congregation. Polk says:

> Practical theology focuses holistically on the entire range of dynamics that characterize life in a community of faith. This focus is generating seminal studies in the variety and complexity of actual congregational life. It is also contributing significantly to a broadening of practical seminary education beyond the preparation of clerical professionals to embrace the pastor's equipping of the saints for their own engagement in genuine ministry. Practical theology acknowledges the key role of praxis in the achievement of new understandings. The"Praxis" denotes a dialectical integration of critical reasoning and creative action in a particular social setting, leading to both change and insight and calling for renewed engagement with the now-altered given situation. Practical theology must necessarily develop a sufficient "hermeneutic of situations"—a "science of interpretation," that provides for today's situations what traditional hermeneutics does for the interpretation of biblical and other historical texts. This task entails discovering the categories and methods of "thick description" that will do justice to the complexity of lived experience. It also includes the critical exposing of cultural and ideological biases that participant-observers bring with them to the interpretive task. Practical theologians will necessarily be open and alert dialogue partners with social scientists. This aspect is not a matter of pure receptivity on the theological side, nor does it define practical theology as one social science among others. It requires a dialectic of engagement in which the work of the various social sciences is critically appropriated. In this regard, practical theology is entirely in concurrence with developments in biblical and historical disciplines.[50]

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[49] Polk, *Handbook of Christian Theology*, 399-400.

[50] Polk, *Handbook of Christian Theology*, 399-400.

A theology of pastoral care must be done in partnerships with mental health communities spiritual and religious leaders and congregations. Practical theology supports that he examines our disciplines of social sciences with developments of biblical and historical tradition. Practical theology and a theology of mental health supports that all disciplines form an interdisciplinary team for effectiveness and change, Polk also states:

> Practical theologians insist on being taken seriously as co-participants in the construction of theological concepts. Theological activity is no longer undertaken in a vacuum. Circumstances and settings fundamentally shape theological understandings. What becomes necessary at this juncture is the effective engagement of "classical" and "practical" scholars in mutually informative and critically corrective inquiries into the very nature of what they seek to understand.[51]

A theology of mental health care follows the same goals of practical theology as "The aim of practical theology is not only to understand the world, but also to change it—and even to be changed in the process. The formation and transformation of persons-in-community, and of the environs impacted by them, are very much at the heart of practical theology's fundamental orientation."[52]

Black Theology

A theology of mental health is foundational to my project because of the context for ministry of serving an African American congregation. The theology of mental health comes from black liberation theology as African American congregations and people connect with familiar biblical stories in which a language is formulated. This type of black theology allows African Americans to be able to connect their God of the Bible and

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[51] Polk, *Handbook of Christian Theology,* 399-400.

[52] Polk, *Handbook of Christian Theology,* 399-400.

then use those experiences and their self-expression to help have faith in themselves, God and their mental well-being. Unfortunately, many people are connected to their biblical stories but never transition into seeing themselves in biblical characters. People must be able to make the connections as seen in a theology of mental health, as seen in all of human behavior. A theology of mental health supports individuals, especially African-Americans to see their value and worthy. Theologian James H. Evans states,

> Black theology is also a biblical theology. A great deal of the religious self-understanding of black people is expressed in biblical language. This biblical language is not simply the result of black people reading and reiterating the Bible. Rather, this language has become an integral part of black self-expression. One must not underestimate the role the Bible played in the formation of the folklore of black people. Biblical images became so interwoven into the fabric of black experience that now it is almost impossible to appreciate black folklore fully without attention to the Bible. The Bible is a text that is not simply the possession of the black church; rather, it is part of the language of the black community as a whole. The Bible became so important for black people in America because in it they saw their own experiences reflected. Therefore, they understood themselves to be a pan of the tradition of the faithful of history for whom the Bible was the standard by which fidelity was measured.[53]

African Americans must see themselves as part of God and seen in the role of understanding and valuing their history as well as getting healed from the wounds, oppression and rejections of the past. A theology of mental health helps individuals especially African Americans find their voice and power through working on their healing and restoration of their mental understanding of themselves.

A theology of mental health helps African American formulate a new theology of using their mind, value and worth by helping to change how they see themselves mentally. Theologian James Cone stated this in theological terms of freedom and

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[53] James H. Evans Jr., *Handbook of Christian Theology* (Nashville, TN: Abingdon Press, 2003), 74-80.

liberation.[54] Theologian and Professor Dwight Hopkins and many of black liberation theologians stated that black liberation theology is revolutionary as the mission of Jesus was to help bring freedom and liberation.[55] A theology of mental health helps and support freedom and liberation mentally for all people and especially African-American people. Dr. Martin L. King Jr. in his Letters from a Birmingham Jail stated "Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."[56]

A theology of mental health the freedom, liberation and support of all people which was demonstrated by the mission of Jesus and furthered by many black liberation theologians as theological, social, human and psychological injustice.

Process Theology

Process theology is foundational toward a theology of mental health it provides a basic for understanding the value of the human mind and its experience. Process theology incorporates and intergrades science and religion into a religious system for which a theology of mental health support. This process of becoming uses the human mind and its experiences with a direct connection with God to form its theology. Theologian David Ray Griffin describes this basis for process theology as "panexperienctialsim" which is connected to forming a theology of mental health:

> Based on the thought of Whitehead and Hartshorne, process theology is one of the few contemporary types of theology grounded in a metaphysical position in which

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[54] James Cone, *God of the Oppressed* (Maryknoll, NY: Orbis, 1997).

[55] Dwight N. Hopkins, *Introducing Black Theology of Liberation* (Maryknoll, NY: Orbis, 1994).

[56] Martin Luther King Jr., "Letter from Birmingham Jail," *The Atlantic Monthly* 212, no. 2 (August 1963): 278-288.

> theism is defended philosophically and science and religion are included within the same scheme of thought. The term "process" signifies that the "really real" is not something devoid of becoming, be it eternal forms, an eternal deity, bits of matter, or a substance thought to underlie changing qualities. The really real things, the actual entities, are momentary events with an internal process of becoming. This internal process, called "concrescence" (meaning becoming concrete), involves some degree of spontaneity or self-determination. It is also experiential. Actual entities are thus said to be "occasions of experience." The experience need not be conscious; consciousness is a very high level of experience that arises only in high-grade occasions of experience. But, even though events at the level of electrons, molecules, and cells do not have consciousness, they have feelings and realize values, however trivial. The term "panexperientialism" can be used to describe this view, but it means not that all things, but only that all individuals, have experience: Things such as rocks are aggregates, which have no experiential unity, therefore no feelings or purposes. The position is, accordingly, best called "panexperientialism with organizational duality.[57]

This "panexperientialism" states that human being are not just having experiences but experiences moments of "consciousness of human desires, fears, evaluations and thoughts, emotions, dreams and choices" that are apart of this human experience. This human experience is spontaneous in nature and leads to human freedom as seen in a theology of mental health. When individual become empowered to "be" and "think freely" then they can enjoy the benefits of self-healing and restoration as they are "becoming." fully human.[58]

In this process, self- awareness of each individual's human experience is key in process theology. Self-awareness becomes also vital in understanding a theology of mental health as one is becoming aware of their own feelings and value and providing meaning within their own mind. The process of becoming and consciously aware of the relationship with God, self and others become vitally important in forming a theology of

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[57] David Ray Griffin, *Handbook of Christian Theology* (Nashville, TN: Abingdon Press, 2003), 403-408.

[58] Griffin, *Handbook of Christian Theology*, 403-408.

mental health. The human mind and nature therefore creates a joining together of science and religion into a "religious ecological vision and ethic."[59] Griffin describes the use of the human mind and nature into a "religious ecological vision and ethic."[60] Griffin states:

> This view provides a solution to the modem mind-body problem created by the assumption that "matter" is completely devoid of spontaneity and experience and therefore different in kind from "mind." Because the mind is different only in degree from the brain cells, not in kind, the interaction of brain and mind is not unintelligible. One can therefore avoid materialism's reductionistic treatment of mind and idealism's reductionistic treatment of matter, affirming instead the equal reality of the human mind, with its freedom, and of the rest of nature, with its integrity apart from the human perception of it. This resolution provides the basis for a theology of nature that not only reconciles science and religion but also supports a religious ecological vision and ethic. Four features of the portrayal of nature are crucial for this ecological vision.[61]

The human life of Christ shows that God is directly related to the human experience as the Divine Presence seen in all human beings. A theology of mental health believes that God is not separated from the human experience through our minds. Griffin further the discussion as the proper way to view Christology. Griffin states:

> This doctrine allows process theologians to speak of human religious experience as one in which God is directly experienced and thereby becomes incarnate in the experiencer. This idea provides, in turn, the basis for a Christology in which incarnation is spoken of literally. The task for Christology proper is to show not how God could have been present in Jesus, but how this presence could have been different enough from the divine presence in all people, indeed in all individuals, to justify taking Jesus as of decisive importance.[62]

A theology of mental health support that there is no duality between humanity and nature of the world. Griffin further explains the connect of God and nature as one system for which process theology stands. This understanding helps to provide "intrinsic value" and

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[59] Griffin, *Handbook of Christian Theology*, 403-408.

[60] Griffin, *Handbook of Christian Theology*, 403-408.

[61] Griffin, *Handbook of Christian Theology*, 403-408.

[62] Griffin, *Handbook of Christian Theology*, 403-408.

worth to a theology of mental health. Each individual mental thought becomes important in understanding this "intrinsic value" [63] Griffin describes this understanding in terms of process theology. Griffin states:

> First, there is no dualism between humanity and nature. All individuals are said to have intrinsic value and therefore to be worthy of respect as ends in themselves. The anthropocentrism of most Christian theology, especially in the modem period, is thereby overcome. God did not create nature simply as a backdrop for the divine—human drama, and certainly not for human plunder, but cherishes individuals of each kind for their own sakes. Second, ... process theology does not proclaim the idea that all individuals have the same degree of intrinsic value. A chimpanzee has more intrinsic value than a microbe, a human more than a malarial mosquito. A basis is thereby provided for discriminating value judgments. Third, the units of which the world is composed are momentary events (not enduring substances), which constitute themselves by unifying aspects of other events in the environment into a creative synthesis. Relations to others are therefore internal to an individual; these relations are constitutive of what the individual is. One's welfare is therefore tied up with the welfare of one's world. This idea drastically reverses the picture, pervasive especially in the modem period, of a world made up of substances whose relations to others are mainly external to them. Some have come to refer to process theology as "process-relational theology" in order to emphasize this point; it has also been called the "postmodern ecological worldview." One implication for an ecological ethic of this point about internal relations is that it prevents the hierarchy of intrinsic value from leading to the conclusion that species with less intrinsic value should be eliminated to make room for increased populations of those with greater intrinsic value. The ecological as well as the intrinsic value of all things must be considered. A fourth point is that the "others" included in each event are not simply the other finite processes in the environment but the all-inclusive process, God. God is therefore pervasive of nature, present in every individual, from electrons to amoebas to birds to humans. Each species is worthy of reverence as a unique mode of divine presence.[64]

A theology of mental health affirms a divine presence in human life. A mental health theology also affirms that God is inclusive in the world and is concerned about the human experience being lived out through the mental processes.

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[63] Griffin, *Handbook of Christian Theology*, 403-408.

[64] Griffin, *Handbook of Christian Theology*, 403-408.

David Griffin furthers this theology as seen in process theology with the importance of nature and experience:

> Correlative with process theology's doctrines of nature and experience are its doctrines of God and the God—World relation. Process theology rejects the idea that the world is a purely contingent product, wholly external to God. Rather, God is essentially the soul of the universe, so that God has always interacted with some universe, in the sense of a multiplicity of finite actual entities.[65]

God is the essential soul of the universe is very helpful in understanding the power of the mind in using a theology of mental health. God is concerned about all aspects of our mental health and well-being. Unfortunately, fears and negative experiences on how a therapist might respond keep may persons in the religious community from receiving counseling services because of fear. [66]

Conclusion

A theology of mental health is a significant access point to effectively addressing the challenges that arises spiritually, mentally and emotionally for persons innately connected to the religious and spiritual community. Theology and spirituality has its right place in the provision of services in mental health counseling as well as mental health training should have a place in our religious settings. Hoogestraat and Trammel asserted that, "All humans are spiritual beings. Spiritual [affects] mental, physical and emotional health; and it is essential to address spiritual and religious issues in therapy to maintain ethical care."[67] This is vital in a theology of mental health as religious and spiritual

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[65] Griffin, *Handbook of Christian Theology*, 403-408.

[66] Joshua Gold, *Counseling and Spirituality* (Upper Saddle River, NJ: Pearson Education, Inc., 2010), xvi.

[67] Gold, *Counseling and Spirituality*, xv.

congregations and leadership are addressing the mental, physical and emotional needs within the congregation.

A theology of mental health addresses the duality that there are not examples of integrating the emotional, spiritual and mental experiences of people in these communities. A theology of mental health requires doing theology from a pastoral care and counseling perspective as well as being in partnership with the mental health and social service communities. A theology of mental health requires that minister or religious leader to be clinically trained in areas of mental health awareness as well as having knowledge of the behavioral sciences.

John Swinton states, "Mental health problems are unique experiences that occur in the lives of irreplaceable individuals who have their own unique stories, histories, dreams, and desires; people who are deeply loved by God, and whom God desires God's church to love with boundaries. People's stories may be changed by their encounter with mental health problems but they are not defined by them."[68] The United Methodist church supports the components of mental health based on the Wesley theology and the theological statement indicates:

> We believe that faithful Christians are called to be in ministry to individuals and their families challenged by disorders causing disturbances of thinking, feeling and acting categorized as "mental illness." We acknowledge that throughout history and today, our ministries in this area have been hampered by lack of knowledge, fear and misunderstanding. Even so, we believe that those so challenged, their families and their communities are to be embraced by the church in its ministry of compassion and love.[69]
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> Our model is Jesus, who calls us to an ethic of love toward all. As Jesus proclaimed the reign of God, his words and proclamations were accompanied by

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[68] Swinton, "Time, Hospitality, and Belonging," 171.

[69] "Ministries in Mental Health," The United Methodist Church, accessed December 14, 2016, www.umc.org.

> "healing every disease and every sickness" (Matthew 9:35). Jesus had compassion and healed those besieged by mental illness, many of whom had been despised, rejected, persecuted and feared by their community. John Wesley and the founders of The United Methodist Church practiced a faith grounded in the redemptive ministry of Jesus Christ, with a focus on healing the whole person: physical, spiritual, emotional and mental. The concern for the health of those within the ministry of the church led to establishment of medical services for those in need without regard to financial means, thereby refusing no one for any reason. That spirit of all-encompassing love and compassion serves as a legacy and a model for us as we seek to respond to those challenged by mental illness. Today, because of the achievements of the scientific and medical communities, we know more about the causes and treatment of the many disorders considered "mental illnesses." More important, we know that the gift of healing is one of the spiritual gifts received from God. The call of those baptized in Christ includes a mandate to exercise the gift of healing by the church as evidence of God's love, a precursor to the reign of God, and a sign of the presence of God's Holy Spirit through the community of the church. We therefore commit ourselves to the following: 1) learn more about the causes of mental illnesses; 2) advocate for compassion and generosity in the treatment of mental illnesses; and 3) prayerfully lead our congregations to be in ministry, demonstrating that our church, as the body of Christ, can work to provide the means of grace that leads to wholeness and healing for all.[70]

The United Methodist Church further states a theology of mental health as:

> The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Unfortunately, mental health eludes many in our world resulting in considerable distress, stigma, and isolation. Mental illness troubles our relationships because it can affect the way we process information, relate to others, and choose actions. Consequently, mental illnesses often are feared in ways that other illnesses are not. Nevertheless, we know that regardless of our illness we remain created in the image of God (Genesis 1:27) and that nothing can separate us from the love of God (Romans 8:38-39).[71]

The United Church of Christ address a theology of mental health as a commandment to love one another which aligns with a theology for and of mental health. The United Church of Christ states,

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[70] "Ministries in Mental Health," accessed December 14, 2016, www.umc.org.

[71] "Ministries in Mental Health," accessed December 14, 2016, www.umc.org.

There exists in society and even in the church, great stigma and discrimination against persons with serious "mental illnesses" (Brain Disorders); this is both a ministry and a social justice issue. All people are created in the image of God and worthy of being treated with dignity, respect and love. "I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another" (1 John 13:34-35).[72]

[72] "Ministries in Mental Health," accessed December 14, 2016, www.umc.org.

CHAPTER FIVE

THEORETICAL FOUNDATIONS

In this chapter, the contemporary theories will be examined focused on the integration and the importance of spirituality, psychology and mental health initiatives within the United Methodist Church and the United Church of Christ. Using research from an African American's reluctance to receive mental health services, this chapter will show the ineffectiveness of African American congregations to receive mental health services. Often times, the stigma of mental health causes an avoidance of persons understanding mental health and also receiving mental health services when needed. The strong connection and co-dependency on the religious and spiritual community causes many persons not to receive the necessary training. The lack of mental health professional that African Americans can identify with and the lack of clinical training and understanding of the importance of mental health in the local congregation causes this community to further suffer.

This chapter will examine areas of clinical pastoral education from two main clinical training organizations that will be useful in developing the anticipated doctoral project. This chapter will also examine the theoretical approach from the behavioral science of psychology and pastoral counseling as ways to incorporate the mental health awareness and competencies.

Theoretical Foundations in Ministry Practice

There are theoretical models that have addressed mental health in congregations. There are many churches that have mental health counseling center with licensed mental health professions, however many of these churches have professional trained in mental health but lack formal or religious training or professionals trained in theology and lack the full clinical training required to fully assess, diagnosis or treat mental health. Many congregants look to their religious leadership for direction when facing a mental health crisis, however most religious or spiritual leaders are not clinically trained in mental health, have knowledge of the referral process or have built relationships with the mental health communities.

Marsha Wiggins Frame supports this religious and spiritual development and models as she states,

> Theoretical methods oriented around religious and spiritual development are useful to counselors because they provide frameworks for understanding how clients incorporate their faith. Frame also argues that "when counselors and clients are able to acknowledge that there are predictable ways in which people grow in their faith, then it is easier to respond to particular manifestations of religion or spirituality in an open and accepting manner. These tools provide counselors with the tools to make sense of their own spiritual journeys. Because gaining increased self-awareness is central to the work of effective counseling, having the knowledge of various development theories enables counselors to see how their own development compares with that of their clients.[1]

Mental Health: A Guide for Faith Leaders

One effective mental health resource from the American Psychiatric Association entitled, "Mental Health: A Guide for Faith Leaders" provides a mental health overview

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[1] Marsha Wiggins Frame, *Integrating Religion and Spirituality into Counseling: A Comprehensive Approach* (Pacific Grove, CA: Thompson Cole and Brooks, 2003), 35-36.

and shows how faith leaders can support people with mental illness. Within this guide it addresses what mental health is, a brief overview of common mental illness, suicide, diagnosis, mental health treatment, the connection between mental and physical conditions and recovery, wellness and building resilience.[2]

In the second part in support faith leaders for mental health, this section addresses how congregations can be more inclusive and welcoming, when to make a referral to a mental health professional, how to make a referral for mental health treatment, dealing with resistance to accepting mental health treatment, distinguishing religious or spiritual problems from mental illness and approaching a person with an urgent mental health concern.[3] This guide is a vital resource for the doctoral project because it addresses all the components that would be used in the educating congregations around the importance of mental health and mental health awareness.

Wittmer and Sweeney addresses an optimal functioning of wellness and mental health which addresses spirituality. Wittmer and Sweeney describe the optimal functioning of wellness as, "Optimal functioning of wellness: Spirituality (values, beliefs, ethics, purpose and direction, optimism, and inner peace); self-regulation (sense of worth, mastery of one's own life, spontaneity and emotional responsiveness, sense of humor, creativity, awareness of reality, and physical health); work (paid employment, volunteer experiences, child rearing, and physical health); friendship (positive interpersonal relationships and social supports that provide rewarding activities and interactions); and

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[2] "Mental Health: A Guide for Faith Leaders," American Psychiatric Association, accessed December 14, 2016, www.psychiatry.org.

[3] "Mental Health," accessed December 10, 2016, www.psychiatry.org.

love (intimacy, trust ,sharing and cooperative long–term relationships." [4] This model addresses the spiritual and emotional components of mental health and wellness which can be useful in the doctoral project.

Purdy and Dupey address a holistic model of spiritual wellness that supports mental health and wellness. Purdy and Dupey state that The Holistic Model of Spiritual Wellness includes a belief in an organizing force in the universe; a notion of connectedness; faith; movement toward compassion; the ability to find meaning in life; the ability to find meaning in death.[5]

Lack of Mental Health Models for African American Congregations

The doctoral project serves a predominantly African American congregation. Researchers suggest that African Americans are less likely to receive services including mental health services. There are very few models that address mental health in the African American church context, however the statistics show the lack of services, understanding or lack of receiving mental services.

The National Institute of Mental Health and Substance Abuse and Mental Health Service Administration reports, "Mental illness is common: 1 in 5 (19%) U.S. adults experience some form of mental illness in a given year; 1 in 24 (4.1%) has a serious mental illness; and 1 in 12 (8.5%) has a substance abuse disorder."[6] The numbers are

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[4] J. M. Witmer and T. J. Sweeney, "A Holistic Model for Wellness and Prevention over the Lifespan," *Journal of Counseling and Development* 71, no. 2 (1992): 140-148.

[5] M. Purdy and P. Dupey, "Holistic Flow Model of Spiritual Wellness," *Counseling and Values* 49, no. 2 (2005): 95-106.

[6] "Mental Health," accessed December 10, 2016, www.psychiatry.org.

even higher for African American populations.[7] Historically, the African Americans have been less likely to receive mental health services due to many systematic barriers and stigmas from the African American community. The National Alliance on Mental Health states:

> The National Alliance on Mental Health (NAMI) discussing African-Americans and mental health says that according to the Health and Human Services Office of Minority Health states that African- Americans are 20% more likely to experience serious mental health problems than the general population. African- Americans are most likely to experience major depression, attention deficit hyperactivity disorder (ADHD), suicide especially among African-American men and post traumatic disorder (PTSD) because African-Americans are most likely to be victims of violent crime. African- Americans are also most likely to experience certain factors that increase the risk for developing a mental health condition like homelessness-people experiencing homelessness are at a greater risk of developing a mental health condition. African-Americans make up 40% of the homeless population. Secondly, exposure to violence increases the risk of developing a mental health condition such as depression, anxiety and post-traumatic stress disorder. African-American children are more likely to be exposed to violence than other children.[8]

Jamie Rose Hackett discusses in her work concerning these systemic barriers that prevent African- Americans from receiving mental health services:

> African Americans are overrepresented in high-risk populations and are known to experience disadvantages in mental health services. In an effort to better understand the barriers that prevent African Americans from receiving adequate mental health services; this study explores barriers on multiple system levels and the implications for clinical practice. This study also explores the relevance and impact of historical trauma. Qualitative interviews were used to collect the experiences of African American clinicians in the mental health field working with African American clients. Findings revealed twelve themes that are consistent with previous research. These themes are; historical trauma, stigma, cultural stereotypes, cultural mistrust, informal support, lack of African American professionals, cultural competency, issues in assessment, misdiagnosis, cultural paranoia, treatment, and economic inequality. These themes show the systematic issues that prevent African Americans from seeking and receiving adequate

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[7] "Mental Health," accessed December 10, 2016, www.psychiatry.org.

[8] Amanda Wang, "African American Mental Health Voices from NAMI," accessed October 14, 2016, http://www.nami.org/Find-Support/Diverse-Communities/African-Americans#sthash.9yMfFulE.dpuf.

> mental health services. Implications for clinical practice and opportunities for change are discussed.[9]

Most African Americans have traditionally turned to their faith in God, prayer and the local church for hope and support in times of crisis and trauma. "According to the National Mental Health Association, 27% of African Americans said that if they experienced depression, they would handle it with prayer and faith alone."[10]

Historically, the African American church has been a strong social and religious force of unity and is held in the highest esteem by many African Americans.[11] Researchers have also found that African Americans report higher levels of religious and church affiliation than the general population.[12] According to Boyd-Franklin and Hackett, they suggest that:

> Spirituality has been a survival mechanism that has contributed to the resiliency of African Americans in coping with the psychological pain of racism, discrimination, and oppression. The high reliance on informal supports has contributed to the lack of African Americans to seek more formal support services. As noted, this particular theme is recognized as a strength and barrier.[13]

National Alliance on Mental Illness state:

> Only about one-quarter of African Americans seek mental health care, compared to 40% of whites. Here are some reasons why:
> Distrust and misdiagnosis. Historically, African Americans have been and continue to be negatively affected by prejudice and discrimination in the health care system. Misdiagnoses, inadequate treatment and lack of cultural competence

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[9] Jamie Rose Hackett, "Mental Health in the African American Community and the Impact of Historical Trauma: Systematic Barriers," accessed October 14, 2016, http://sophia.stkate.edu/msw_papers/320.

[10] B. Perdue, D. Singley, and C. Jackson, "Assessing Spirituality in Mentally Ill African Americans," *ABNF Journal* 17, no. 2 (2006): 78-81.

[11] N. Boyd-Franklin, *Black Families in Therapy: Understanding the African American Experience* (New York, NY: The Guilford Press, 2003).

[12] N. Boyd-Franklin, "The Contribution of Family Therapy Models to the Treatment of Black Families," *Psychotherapy: Theory, Research, Practice, Training* 24, no. 3 (1987): 621-629.

[13] Boyd-Franklin, "Family Therapy Models," 621-629.

> by health professionals cause distrust and prevent many African Americans from seeking or staying in treatment. Socio-economic factors play a part too and can make treatment options less available. According to the U.S. Census Bureau, as of 2012, 19% of African Americans had no form of health insurance. The Affordable Care Act is making it easier and more affordable to get insured. Lack of African American mental health professionals. Only 3.7% of members in the American Psychiatric Association and 1.5% of members in the American Psychological Association are African American.[14]

Richardson's studies on African American clergy's attitude toward mental health professionals showed that African American clergy are experiencing an identity crisis but it is possible for both disciplines to work together to help the community. Richardson states:

> In conclusion, this study found that black clergy held favorable attitudes toward mental health professionals—a conclusion which did not lend support to the popular notion that black clergy are experiencing a crisis of identity. An important implication of this research is that the possibility exists for black clergy and mental health professionals to work together to help foster the social, spiritual, and psychological well-being of persons in the black community.[15]

Corrigan suggest that these stigmas are ""social-cognitive" processes [that] motivate people to avoid the label of mental illness that results when people associated with mental health care."[16] These "social-cognitive" processes and labels have to be addressed in the African American church and the community for mental health to be relevant and become a serious concern in the community.

African American congregations need culturally-specific models of care. Tonya Armstrong urges that congregational care needs of African American congregations need

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[14] "African American Mental Health," National Alliance on Mental Illness, accessed November 18, 2016, www.nami.org.

[15] Bernard Richardson, Attitudes of Black Clergy Toward Mental Health Professionals: Implications for Pastoral Care, *Journal of Pastoral Care* 43, no. 1 (Spring 1989): 39.

[16] P. Corrigan, How Sigma Interferes with Mental Health Care, *American Psychologist* 59, no. 7 (2004): 614-625.

to be culturally-specific in providing care.[17] Armstrong states that congregations need: "(1) helping suffering people to access sustained mental health care, particularly in a large/mega-church: and (2) helping suffering people with multi-layered challenges to access appropriate, skilled care that transcends traditional barriers and is consistent with their faith."[18]

Armstrong suggest that this "model of congregational care is (should be) presented with concrete examples of how cultural, theological, and strategic concerns are discussed, with broad implications for diverse faith communities."[19] This view can be very helpful for African- American churches creating diverse congregational care and counseling support. Armstrong suggests that there are additional barriers that affect mental health in African-Americans communities.[20] These barriers are "financial challenges, lack of understanding about mental disorders, mistrust of psychotherapists (particularly psychologists), and a preference for cultural sensitivity."[21]

Denominations Addressing Mental Health within Congregations

The United Methodist Church has a well-developed statement on the importance of mental health in congregations. The information provided on the website show that the denomination acknowledges the need for mental health awareness and the call to address

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[17] Tonya D. Armstrong, "African-Americans Congregational Care and Counseling: Transcending Universal and Cultural-Specific Barriers," *Journal of Pastoral Care and Counseling* 70, no. 2 (2016): 118-122.

[18] Armstrong, "African-Americans Congregational Care," 118-122.

[19] Armstrong, "African-Americans Congregational Care," 118-122.

[20] Armstrong, "African-Americans Congregational Care," 118-122.

[21] V. L. S. Thompson, A. Bazile, and M. Akbar, "African-Americans' Perception of Psychotherapy and Psychologists," *Professional Psychology: Research and Practice* 35 (2004): 19-26.

the stigma, however there seems to be a lack of clinical models, a requirement for clinical training or information on establishing partnerships with mental health agencies. The United Methodist Church states:

> The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." Unfortunately, mental health eludes many in our world resulting in considerable distress, stigma, and isolation. Mental illness troubles our relationships because it can affect the way we process information, relate to others, and choose actions. Consequently, mental illnesses often are feared in ways that other illnesses are not. Nevertheless, we know that regardless of our illness we remain created in the image of God (Genesis 1:27) and that nothing can separate us from the love of God (Romans 8:38-39). No person deserves to be stigmatized because of mental illness. Those with mental illness are no more violent than other persons are. Rather, they are much more likely to be victims of violence or preyed on by others. When stigma happens within the church, mentally ill persons and their families are further victimized. Persons with mental illness and their families have a right to be treated with respect on the basis of common humanity and accurate information. They also have a right and responsibility to obtain care appropriate to their condition. The United Methodist Church pledges to foster policies that promote compassion, advocate for access to care and eradicate stigma within the church and in communities.[22]

The United Methodist Church further states education around mental health in the community entitled, *Challenges Facing Persons with Mental Illness and their Congregations and Communities.*[23] The website states,

> Mental illness is a group of brain disorders that cause disturbances of thinking, feeling, and acting. Research published since 1987 has underscored the physical and genetic basis for the more serious mental illnesses, such as schizophrenia, manic-depression, and other affective disorders. Treatment should recognize the importance of a non-stressful environment, good nutrition, and an accepting community. All aspects of health-physical, mental, and spiritual-were of equal concern to Jesus Christ, whose healing touch reached out to mend broken bodies, minds, and spirits with one common purpose: the restoration of well-being and

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[22] "Ministries in Mental Health," The United Methodist Church, accessed November 18, 2016, www.umc.org.

[23] "Ministries in Mental Health," The United Methodist Church, accessed November 18, 2016, www.umc.org.

> renewed communion with God and neighbor We are blind when it comes to the needs of those individuals and families that live with mental illness, and for too long the body of Christ has associated mental illness with the story of the man from Gadara, a man possessed by evil spirits. Instead may the body of Christ consider this story: "Taking the blind man's hand, Jesus led him out of the village ellipsis. [Jesus] asked him, 'Do you see anything?' The man looked up and said, ['It is not clear']. Then Jesus placed his hands on the man's eyes ellipsis; [and] his sight was restored, and he could see everything clearly. Then Jesus sent him home" (Mark 8:22-26). This man is suggestive of the countless individuals, in our time as well as his, whose mental dysfunction makes him blind to his value in society, but also makes us blind to the painful stigmatization, isolation, incarceration, and restraint that people living with mental illness endure. But like the man who was blind, Jesus is helping both him and us to heal. Many interventions are needed to heal the often chronic conditions of the brain and nervous system, known as mental illness. The body of Christ needs deeper healing in understanding, education, compassion, and adequate ways to support the families and individuals living with mental illness. Those impacted by mental illness also need to be supported in their quest for healing, knowing that most often Jesus heals over time, using a variety of healing modalities. Precisely because mental illness affects how we think, feel or act, it has an impact on our ability to function in community with others.[24]

The United Methodist addresses signs of a mental health diagnosis. They state: "There are many reasons that explain why persons with a mental illness diagnosis exhibit difficult or disruptive behaviors. The reasons include traumatic events like abuse or domestic violence; a life of physical or emotional poverty; deprivation of social experiences and limited social skills; and behaviors due to loneliness, being misunderstood, being powerless, or the absence of joy in their lives."[25]

The United Methodist Church also challenges the stigma, incarceration, de-institutionalism, and the misunderstanding of faith dealing with mental health and their commitment to the community. The United Methodist Church states,

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[24] "Ministries in Mental Health," The United Methodist Church, accessed November 18, 2016, www.umc.org.

[25] "Ministries in Mental Health," The United Methodist Church, accessed November 18, 2016, www.umc.org.

1. Stigma-Stigma has been with us for millennia and remains a major issue today. When the man of Gadara said his name was "Legion"; because we are many," his comment suggests the countless individuals in every age, whose mental dysfunction causes fear, rejection, or shame, and to which we tend to respond with the same few measures no more adequate for our time than for his: stigmatization, isolation, incarceration, and restraint. Jesus embraced and healed such persons with special compassion (Mark 5:1-34).

2. Incarceration-We believe all persons with a mental illness diagnosis should have access to the same basic freedoms and human rights as other persons in a free society. A fine line of distinction exists between criminal violation of the law and behavior that is criminalized because law enforcement agencies have had no other recourse for handling persons whose actions resulted from mental illness symptoms that affect thinking, perceptions and behavior. We oppose the use of jails and prisons for incarceration of persons who have serious, persistent mental illnesses for whom treatment in a secure hospital setting is far more appropriate. Moreover, many incarcerated persons with mental illness need psychiatric medications. Citing economic reasons as the cause for failure to provide medications to a person who needs them is unacceptable, as is imposing medication compliance as a condition of release or access to treatment and other services.

3. Deinstitutionalization-We express particular concern that while the process followed in the United States and some other nations in recent years of deinstitutionalizing mental patients has corrected a longstanding problem of "warehousing" mentally ill persons, it has created new problems. Without adequate community-based mental-health programs to care for those who are dehospitalized, the streets or prisons have become a substitute for a hospital ward for too many people. Consequently, often the responsibility, including the costs of mental-health care, has simply been transferred to individuals and families or to shelters for the homeless that are already overloaded and ill-equipped to provide more than the most basic care. Furthermore, the pressure to deinstitutionalize patients rapidly has caused some mental-health systems to rely unduly upon short-term chemical therapy to control patients rather than employ treatments that research has demonstrated are successful.

4. Misunderstanding of Faith-Sometimes Christian concepts of sin and forgiveness, are inappropriately applied in ways that heighten paranoia or clinical depression. Great care must be exercised in ministering to those whose mental illness results in exaggerated self-negation. While all persons stand in need of forgiveness and reconciliation, God's love cannot be communicated through the medium of forgiveness for uncommitted or delusional sins.[26]

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[26] "Ministries in Mental Health," The United Methodist Church, accessed November 18, 2016 www.umc.org.

Last the United Methodist Church discusses the response to mental health based upon the ministry of John Wesley in terms of providing healing, addressing congregations and its mission of salvation and reconciliation, communities, education, clergy support and legislation.

> John Wesley's ministry was grounded in the redemptive ministry of Christ with its focus on healing that involved spiritual, mental, emotional, and physical aspects. His concern for the health of those to whom he ministered led him to create medical services at no cost to those who were poor and in deep need, refusing no one for any reason. He saw health as extending beyond simple biological well-being to wellness of the whole person. His witness of love to those in need of healing is our model for ministry to those suffering from mental illness.
>
> *1. Healing*-Effective treatment recognizes the importance of medical, psychiatric, emotional, and spiritual care, psychotherapy or professional pastoral psychotherapy in regaining and maintaining health. Congregations in every community are called to participate actively in expanding care for persons who are mentally ill and their families as an expression of their nature as the body of Christ.
> Treatment for mental illness recognizes the importance of a non-stressful environment, good nutrition, and an accepting community.
>
> *2. Congregations*
> The church, as the body of Christ, is called to a ministry of salvation in its broadest understanding, which includes both healing and reconciliation, of restoring wholeness both at the individual and community levels. We call upon the church to affirm ministries related to mental illness that embrace the role of community, family, and the healing professions in healing the physical, social, environmental, and spiritual impediments to wholeness for those afflicted with brain disorders and for their families.
> We call upon local United Methodist congregations, districts, and annual or central conferences to promote United Methodist congregations as "Caring Communities." The mission to bring all persons into a community of love is central to the teachings of Christ. We gather as congregations in witness to that mission, welcoming and nurturing those who assemble with us. Yet we confess that in our humanity we have sometimes failed to minister in love to persons and families with mental illness. We have allowed harriers of ignorance, fear, and pride to separate us from those who most need our love and the nurturing support of community.
> United Methodist congregations around the world are called to join the Caring Communities program, congregations and communities in covenant relationship with persons with mental illness and their families. Caring Communities engage intentionally in:

Education. Congregations engage in public discussion as well as responsible and comprehensive education about the nature of mental illness and how it affects society today. Such education not only helps congregations express their caring more effectively, but reduces the stigma of mental illness so that persons who suffer from brain disorders, and their families, can more freely ask for help. Such education also counters a false understanding that mental illness is primarily an adjustment problem caused hy psychologically dysfunctional families. Covenant. Congregations through their church councils enter into a covenant relationship of understanding and love with persons and families with mental illness to nurture them. The covenant understanding may well extend to community and congregational involvement with patients in psychiatric hospitals and other mental-health care facilities. Welcome. Congregations extend a public welcome to persons with mental illness and their families. Support. Congregations think through and implement the best ways to be supportive to persons with mental illness and to individuals and families caring for them. Advocacy. Congregations not only advocate for specific individuals caught up in bureaucratic difficulties, but identify and speak out on issues affecting persons with mental illness and their families that are amenable to legislative remedy.

3. Communities-We call upon the communities in which our congregations are located to develop more adequate programs to meet the needs of their members who have mental illness and their families. This includes the need to implement governmental programs at all levels that monitor and prevent abuses of persons who have mental illness, as well as those programs intended to replace long-term hospitalization with community-based services.

Mental illness courts, properly established, regulated, and administered could and should be maintained to handle cases involving persons with serious mental illnesses. Such courts can ensure compassionate and ethical treatment. These courts are often able to avoid criminalizing behaviors that result from symptoms affecting thought, perceptions, and behavior. When governing bodies institute such courts, they should: understand and embrace an ethical understanding of the compassionate intent of the law in the establishment of mental-health courts when mental illness is a factor in law enforcement. Respect all human rights of persons confined for the purpose of mental-illness treatment in an accredited psychiatric facility, either public or private, including their legal right to have input into their treatment plan, medications and access to religious support as state laws allow. We hold all treatment facilities, public and private, responsible for the protection of these rights.

Depending on the unique circumstances of each community, congregations may be able to support expanded counseling and crisis intervention services; conduct and support workshops and public awareness campaigns to combat stigmas; facilitate efforts to provide housing and employment for deinstitutionalized persons; advocate for improved training for judges, police and other community officials in dealing with persons with mental illness and their families;

We promote more effective interaction among different systems involved in the care of persons with mental illness, including courts, police, employment,

housing, welfare, religious, and family systems; encourage mental health treatment facilities, public and private, including outpatient treatment programs, to take seriously the religious and spiritual needs of persons with a mental illness; and help communities meet both preventive and therapeutic needs related to mental illness.

4. Clergy Support

We call upon the General Board of Higher Education and Ministry to: give attention to addressing issues that arise when United Methodist clergy experience mental illness; and promote the development of pastoral leadership skills to understand mental illness and be able to mediate with persons in their congregations and their communities concerning the issues and needs of persons who have a mental illness.

5. Legislation

We call upon the General Board of Church and Society and other United Methodists with advocacy responsibility to: (a) advocate systemic reform of the health-care systems to provide more adequately for persons and families confronting the catastrophic expense and pain of caring for family members with mental illness; (b) support universal global access to health care, insisting that public and private funding mechanisms be developed to ensure the availability of services to all in need, including adequate coverage for mental-health services in all health programs;(c) advocate that community mental-health systems, including public clinics, hospitals, and other tax-supported facilities, be especially sensitive to the mental-health needs of culturally or racially diverse groups in the population;(d) support adequate research by public and private institutions into the causes of mental illness, including, as high priority, further development of therapeutic applications of newly discovered information on the aspect of genetic causation for several types of severe brain disorders;(e) support adequate public funding to enable mental-health-care systems to provide appropriate therapy;(f) collaborate with the work of entities like the National Alliance on Mental Illness (NAMI), a US self-help organization of persons with mental illness, their families and friends, providing mutual support, education and advocacy for those persons with severe mental illness, and urging the churches to connect with NAMI's religious outreach network. We also commend to our churches globally Pathways to Promise: Interfaith Ministries and Mental Illness, St. Louis, Missouri, as a necessary link in our ministry on this critical issue; and(g) build a global United Methodist Church mental illness network at the General Board of Church and Society to coordinate mental-illness ministries in The United Methodist Church.

6. Seminaries

We call upon United Methodist seminaries around the world to provide technical training, including experience in mental-health units, as a regular part of the preparation for the ministry, in order to help leaders and congregations become

> more knowledgeable about and involved in mental-health needs of their communities.[27]

UCC General Synod Resolution Regarding Mental Illness

The United Church of Christ addresses mental health in terms of definition and a resolution however, there is no real model for mental health within the information and resolution.[28]

The United Church of Christ address a theology of mental health as a commandment to love one another. The church states,

> There exists in society and even in the church, great stigma and discrimination against persons with serious "mental illnesses" (Brain Disorders); this is both a ministry and a social justice issue. All people are created in the image of God and worthy of being treated with dignity, respect and love. "I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another" (1 John 13:34-35).[29]

The United Church of Christ addresses mental health in resolution but seems to focus more on disorders than mental health awareness and models for mental health. The Church states,

> Text of the Resolution
> WHEREAS, serious mental illnesses such as schizophrenia, hipolar disorder (manic depression), unipolar disorder (clinical depression), obsessive/compulsive disorder, panic anxiety disorder are hiological brain disorders and need to be treated as any other biologically based medical problem of any other organ of the body; WHEREAS, the 1990's have been declared the decade of the brain and pioneering research has resulted in new knowledge and new effective medications; WHEREAS, these brain disorders can now be treated as precisely and effectively as other medical disorders (e.g. a higher rate of success in such

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[27] "Ministries in Mental Health," The United Methodist Church, accessed November 18, 2016, www.umc.org.

[28] "Health," The United Church of Christ, accessed November 18, 2016 www.ucc.org.

[29] "Health," The United Church of Christ, accessed November 18, 2016, www.ucc.org.

treatment than for cardiovascular disorders); WHEREAS, there continues to be strong stigma and discrimination in society against people with these brain disorders in social relationships, health insurance coverage, employment, etc.; WHEREAS, there is great inequality in health insurance coverage for these medical conditions compared to coverage of any other physical, medical illness/disorder (diabetes, Parkinson's, etc.); WHEREAS, at least one in four families (including church families) has a family member with one of these brain disorders; WHEREAS, at least 30 million Americans, including at least 12 million children have these brain disorders; and WHEREAS, the church is called to be a community which breaks through fear and isolation to offer love, hope, care and healing; THEREFORE, BE IT RESOLVED that the Twenty-second General Synod requests the United Church Board for Homeland Ministries and/or its successor body to make it a priority to educate congregations about these disorders and encourage congregations to be truly inclusive, welcoming churches, ministering with and to persons with these disorders and their families; BE IT FURTHER RESOLVED that the Executive Council is requested to petition The Pension Boards - United Church of Christ to provide insurance coverage for these brain disorders equal to any other physical illness; and BE IT FINALLY RESOLVED that the Office for Church in Society and/or its successor body is requested to promote advocacy in state legislatures and in Congress for equality in health insurance coverage and other antidiscrimination legislation which affects this population of people. Funding for this action will be made in accordance with the overall mandates of the affected agencies and the funds available.[30]

Theoretical Foundations from Other Disciplines

Mental Health and Clinical Pastoral Education

There was a strong connection between clergy's mental health awareness and how it is seen in the life of the congregation. The clinical pastoral education movement helps to integration clinical training in the area of mental health and spirituality. The movement begins out of a "dissatisfaction with theological education for clergy; of changing views of ministry; of reform in educational theory in general and of reformed professional

[30] "Health," The United Church of Christ, accessed November 18, 2016, www.ucc.org.

education in particular; and of new optimism about the usefulness of psychology in leading to personal fulfillment."[31]

In addressing the ineffectiveness of congregations concerning mental health, it is important to first examine the lack of clinical training in pastoral care and counseling for clergy. This lack of clinical training of the "self" for clergy has congregations to be ineffective in dealing with the mental health and wellness of their congregations. The lack of clinical training requires an integration between the religious beliefs and the behavioral sciences such as psychology.

There is a movement for mental health professionals to be trained in spiritual and religion as well as the religious person to become effective helpers. Many times, religious leaders historically have not considered the integration between spirituality and counseling as a source for helping persons with their mental health issues. There is always a tense relationship between religion and psychological science. The clinical pastoral education movement is a pathway to help integrate the two disciplines for further growth in ministry.

This movement grew from a call of reform for clinical training for clergy by theological educators and physicians with the purpose of "supervised clinical experience as a means to enhance skills, understanding, and personal growth."[32] "CPE has sought to integrate critical reflection, being, and action into the person of the student with attention to caring."[33] The beginning founders of "CPE" had a great influence in the development

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[31] Stephen King, *Trust the Process: A History of Clinical Pastoral Education as Theological Education* (Lanham, MD: University Press of America, Inc., 2007), vii.

[32] King, *Trust the Process*, vii.

[33] King, *Trust the Process*, viii.

of this clinical training. William Keller brought a "socio-structural" approach to pastoral care.[34] Anton Boisen pushed a "experiential-theoretical" approach to pastoral care and Richard Cabot emphasized a "practice oriented" approach to pastoral care.[35] The clinical pastoral education movement is birthed out of many different educational movements. The movements of the general educational theory, adult education, emphasis on being professional and the religion and health movement.

Steven King suggested that there were core competencies around the ACPE CPE model which became the professional identity of the movement.

> First, there was defining activities and service of the profession and the relationship between how human relationships interconnect within a culture as related to God and the world. Secondly, gaining wisdom gained through ongoing reflection upon experiences as reflected model of the practice. Third, a strong commitment to service rather that commercialism. Fifth, a profession that promotes autonomy and accountability. Sixth, a profession that promotes economic and social mobility. This movement placed emphasis on emotional awareness (of self and others), emotional maturity an emotional integration between the clinical experience and self-reflection.[36]

Joshua Gold suggest that when incorporation happens between spirituality and counseling that both parties mutually benefit, the mental health community and the spiritual or religious congregations. Gold states, (1) "an improved professional receptivity to spirituality, (2) a growing acknowledgement of the importance of spirituality and religion as multicultural variables, and (3) an increasing client demand for secular mental health clinicians to address issues of religion and spirituality within mental health services."[37]

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[34] King, *Trust the Process*, vii.

[35] King, *Trust the Process*, viii.

[36] King, *Trust the Process*, 9.

[37] Gold, *Counseling and Spirituality*, xiv.

The College of Pastoral Supervision and Psychotherapy

College of Pastoral Supervision and Psychotherapy address the need for "recovery of the soul" in providing clinical training, certification and training in psychotherapy for ministers and religious and spiritual leaders. This is a vital pathway to helping congregations understand mental health and self-transformation. College of Pastoral Supervision and Psychotherapy CPE/ CPT Standards address a training model in its objectives of clinical pastoral education which provides clinical training for ministers and seminarian students in working with persons within institutions, churches and hospitals through clinical training programs.[38]

The College of Pastoral Supervision and Psychotherapy (CPSP) mission states, "CPE/CPT is designed to provide theological and professional training utilizing the clinical method of learning in diverse contexts of ministry. There are professional benchmarks of expected outcomes from CPE/CPT, which formulate the competency objectives."[39] The CPSP objectives state:

> The objectives of CPSP serve as a basis for clinical education and training for religious and spiritual ministers in a clinical context: The objectives are: 230.1 To develop the ability to make use of the clinical process and the clinical method of learning. This includes the formulation of clinical data, the ability to receive and utilize feedback and consultation, and to make creative use of supervision. 230.2 To develop the self as a work in progress and to cultivate the understanding of the self as the principal tool in pastoral care and counseling. This includes the ability to reflect and interpret one's own life story both psychologically and theologically. 230.3 To demonstrate the ability to establish a pastoral bond with persons and groups in various life situations and crisis circumstances. 230.4 To demonstrate basic care and counseling, including listening, empathy, reflection, analysis of problems, conflict resolution, theological reflection and the demonstration of a critical eye so as to examine and

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[38] "Standards," College of Pastoral Supervision and Psychotherapy, accessed October 16, 2016, www.cpsp.org.

[39] "Standards," College of Pastoral Supervision and Psychotherapy, accessed October 16, 2016, www.cpsp.org.

> evaluate human behavior and religious symbols for their meaning and significance. 230.5 To demonstrate the ability to make a pastoral diagnosis with special reference to the nature and quality of religious values. 230.6 To demonstrate the ability to provide a critical analysis of one's own religious tradition. 230.7 To demonstrate an understanding of the dynamics of group behavior and the variety of group experiences, and to utilize the support, confrontation and clarification of the peer group for the integration of personal attributes and pastoral functioning. 230.8 To demonstrate the ability to communicate and engage in ministry with persons across cultural boundaries. 230.9 To demonstrate the ability to utilize individual supervision for personal and professional growth, and for developing the capacity to evaluate one's ministry.230.10 To demonstrate the ability to work as a pastoral member on an interdisciplinary team. 230.11 To demonstrate the ability to make effective use of the behavioral sciences in pastoral ministry. 230.12 To demonstrate increasing leadership ability and personal authority.230.13 To demonstrate familiarity with the basic literature of the field: clinical, behavioral, and theological.[40]

Association for Clinical Pastoral Education

The Association for Clinical Pastoral Education (ACPE) also provides a clinical training model that could address in the training of persons in mental health as ministers explore training under supervision and tbeir effectiveness in the ministry of self and other contexts for ministry.[41]

ACPE states,

> Clinical Pastoral Education is interfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) into supervised encounter with persons in crisis. Out of an intense involvement with persons in need, and the feedback from peers and teachers, students develop new awareness of themselves as persons and of the needs of those to whom they minister. From theological reflection on specific human situations, they gain a new understanding of ministry. Within the

[40] "Standards," College of Pastoral Supervision and Psychotherapy, accessed October 16, 2016, www.cpsp.org.

[41] "Standards," Association for Clinical Pastoral Education, accessed October 16, 2016, www.acpe.org.

> interdisciplinary team process of helping persons, they develop skills in interpersonal and inter-professional relationships.[42]

ACPE further states the core elements that in clinical training that could be helpful in developing a model for mental health.

> The actual practice of ministry to persons; Detailed reporting and evaluation of that practice; Pastoral Supervision; A process conception of learning; A theoretical perspective on all elements of the program; A small group of peers in a common learning experience; A specific time period; An individual contract for learning consistent with the objectives of CPE; The CPE program must be conducted under the auspices of an ACPE certified supervisor (faculty) attached to an ACPE accredited CPE center.[43]

Pastoral Refection, Pastoral Formation and Pastoral Competence becomes vital in the exploration of understanding clinical pastoral education. This model becomes helpful in assessing and ministering to others. ACPE discuss the definitions of pastoral reflection, formation and competence. ACPE states, "Pastoral Reflection - reflection on one's self as person and pastor in relationship to persons in crisis, the supervisor, and peer group members, as well as the curriculum and institutional setting." Pastoral Formation - focus on personal and pastoral identity issues in learning and ministry. Pastoral Competence - deepening and unfolding of competence in pastoral function, pastoral skills and knowledge of theology and the behavioral sciences."[44]

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[42] "Standards," Association for Clinical Pastoral Education, accessed October 16, 2016, www.acpe.org.

[43] "Standards," Association for Clinical Pastoral Education, accessed October 16, 2016, www.acpe.org.

[44] "Standards," Association for Clinical Pastoral Education, accessed October 16, 2016, www.acpe.org.

Pastoral Competence becomes important in understanding the knowledge of theology and the also promotes training in the behavioral sciences. This incorporation becomes vital in training, helping and educating congregations about mental health.[45]

Pastoral Counseling

The discipline of pastoral counseling supports many aspects of mental health within congregations. Ryan LaMothe discusses the need for pastoral counseling in the twenty first century as using the counseling relationship to assess and diagnosis using psychological theories become vital in understanding the need for mental health. Perhaps, pastoral counseling provides an extension or pathway into religious and spiritual communities regarding their mental health. Ryan LaMothe describes the counseling relationship between the counselor and the client. LaMothe states,

> Pastoral Counseling..... is distinctive in that the counselor's ministry is rooted in the particular ecclesia in which he/she functions and that s/he may represent God and as well as a community of faith. Pastoral counseling is distinctive from secular psychologies because the pastoral counselor relies on a communitarian anthropology to understand human suffering and its healing and sustaining models. This anthropology provides a lens through which the pastoral counselor can further view the counseling relationship itself, diagnosis, along which the counseling goals. Pastoral counselors also use varies psychological theories while understanding the individual as well as the associated processes and aims of counseling.[46]

Following the aims of counseling as well as honoring the spiritual connection and beliefs of the individual become vital in providing mental health in a spiritual or religious community. LaMothe continues to argue that pastoral counseling works best in the

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[45] "Standards," Association for Clinical Pastoral Education, accessed October 16, 2016, www.acpe.org.

[46] Ryan LaMothe, "Pastoral Counseling in the 21st Century: The Centrality of Community," *Journal of Pastoral Care and Counseling* 68, no. 2 (2014): 1-18.

community as the client and patient are developing a mutual relational relationship. LaMothe states:

> The pastoral counseling relationship is a contractual and functional form of association. At its best, the relationship instantiates mutual-personal relations associated with community. The term "client" and "patient" refer both to the functionality and contractual nature of the relationship, struggling with some difficulty in daily living, clients seek the aid of pastoral counselors. If all goes well, they agree to meet for a length of time with the aim of understanding, coming to terms with, and, if possible, alleviating the person's suffering. Ideally, once the counseling has achieved its goals, the relationship terminates. While this is a contractual and functional relationship, it is founded on the good enough pastoral counselor's recognition and treatment of the client as a person and, secondarily, as a client. That is, the terms "client" and "patient" are secondary and subordinate to personalization.[47]

McMinn suggests that Christian counseling is multifaceted because the goals and the nature of counseling. McMinn suggests that Christian counselors are concerned with spiritual growth as well as mental health.[48]

The Integration between Spirituality and Psychotherapy

There is a movement for mental health professionals to be trained in spirituality and religion as well as religious person to become effective helpers. Many times religious leaders historically have not considered the integration between spirituality and counseling as a source for helping persons with their mental health issues.

Joshua Gold suggest that this "mounting attention" "……stems from three roots: (1) an improved professional receptivity to spirituality, (2) a growing acknowledgement of the importance of spirituality and religion as multicultural variables, and (3) an

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[47] LaMothe, "Pastoral Counseling in the 21st Century," 1-18.

[48] Mark R McMinn. *Psychology, Theology and Spirituality in Christian Counseling* (Carol Stream, IL: Tyndale House Publishers, Inc., 1996), 33.

increasing client demand for secular mental health clinicians to address issues of religion and spirituality within mental health services."[49] "In psychology as well as anthropology, religious beliefs and values have long been considered among the defining elements of culture, reflecting a culture's shared perspectives on ethical and existential issues"[50]

Religion and spirituality has its right place in the provision of services in mental health counseling as well as mental health training should have a place in our religious settings. "All humans are spiritual beings. Spiritual [affects] mental, physical and emotional health; and it is essential to address spiritual and religious issues in therapy to maintain ethical care."[51] Unfortunately, fears and negative experiences on how a therapist might respond keep many persons in the religious community from receiving counseling services because of fear. [52] Albert Ellis, a psychologist and the founder of rational emotive therapy, and wrote in the *Journal of Consulting and Clinical Psychology* that there was an irrefutable causal relationship between religion and emotional and mental illness.[53]

Conclusion

The theoretical foundations present in this chapter is anticipated the doctoral project to represent a model of ministry and will serve as resources for building the

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[49] Gold, *Counseling and Spirituality*, xiv.

[50] Gold, *Counseling and Spirituality*, xiv.

[51] Gold, *Counseling and Spirituality*, xv.

[52] Gold, *Counseling and Spirituality*, xvi.

[53] A. Ellis, "Psychotherapy and Atheistic Values: A Response to A. E. Bergin's 'Psychotherapy and Religious Values,'" *Journal of Consulting and Clinical Psychology* 48, no. 5 (1980): 635-639.

project. The theoretical overview shows that the church has addressed mental health from a theoretical perspective but lack the implementation on a contextual perspective. Being aware of the stigma and barriers to this implementation will help with further investigation of the project. Will provide an increase in mental health awareness and cause people to receive mental health services? Perhaps using these models would help with the current anticipated project.

Upon examining the current approaches and methodologies, mental health continues to be a growing subject in many religious and spiritual communities found within The United Methodist Church and also the United Church of Christ, however there some major concerns around the impact of the stigma of mental health and its treatment in the local church. There seems to be many barriers to allowing mental health services within the spiritual and religious communities especially in the African American church and community. Most religious or spiritual leaders and congregations are not equipped to deal with the mental health. Many chose to avoid training or conversations around preventive mental health education due to the stigma and fear. Many religious and spiritual leaders have not identified their mental health challenges and therefore are ill equipped in working with their own mental challenges. This transference and counter transference has cause a disregard to consider partnerships and collaborations other disciplines such psychology, psychiatry and psychotherapy may offer.

Mental health and mental illness continues to be a major issue in the spiritual and religious communities as well as in the many communities at large. The church is called to provide ministry to those suffering from mental health breakdown and challenges. Perhaps by using a clinical pastoral education, a pastoral counseling, an integrative model

between spirituality and psychotherapy, the church can then continue to do the work of being liberator of the spirit and mind.

CHAPTER SIX

PROJECT ANALYSIS

African Americans may be reluctant to discuss mental health issues and seek treatment because of the shame and stigma associated with such conditions. Many African Americans also have trouble recognizing the signs and symptoms of mental health conditions, leading to underestimating the effects and impact of mental health conditions. Community, religious and social stigmas around talking and dealing with mental health has contributed largely to the fact that many people experience shame, guilt and spiritual disconnection even in their religious community. Our community will never heal from the results of these stigmas around mental health if the community continues to be afraid to confront the stigmas, engage and have critical conversations about mental health awareness and wholeness.

In the Integration section of this document, research shows that there must be an integration between the spiritual and the psychological understanding. Mental health is a vital part of one's spiritual growth and development. Spirituality speaks to the holistic approach that affirms that humans are multidimensional and that the different dimensions of life (physical, emotional, mental, spiritual) are transactional, which means they influence each other. A working definition for mental health and illness that was refer to throughout the document is that mental health and illness is any life condition (emotional, psychologically or spiritual) that disrupt a person's thinking, feeling, mood, ability to

relate to others and daily functioning which diminishes one's capacity for coping with the ordinary demands of life and disrupts the social or spiritual connection that God wants us to enjoy.

As stated in the synergy section of this paper, there is a movement for mental health professionals to be trained in spirituality and religion as well as religious person to become effective helpers. Many times, religious leaders historically have not considered the integration

between spirituality and counseling as a source for helping persons with their mental health issues.

A community-based clinical pastoral care and counseling educational program will help lay ministers and clergy develop the basic clinical skills to help effectively support their congregants and the community. This program will address the following community issues and deficiencies of lay leaders and clergy for effective transformational learning within their religious context.

This community-based program must involve supervision that helps students to: 1) understand the self and others as cultural living human documents, 2) articulate a theory, theory of personality, education and group theory that reflects an understands one's culture and the culture of others, 3) develop the ability to supervise students individually and in groups with an awareness of the cultural dynamics that are operative, and 4) develop a CPE curriculum that reflects the cultural diversity of the institution or facility and the community.[1]

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[1] Margaret Benefiel and Geraldine Holton, *The Soul of Supervision* (Pittsburgh, PA: Morehouse Publishing, 2010), 125.

This project will show that the dire need for community clinical mental health training in the local African-American church must address the stigmas of mental health; help churches understand what mental health is: review common mental health illness, address education around suicide and diagnosis; address mental health treatment; discuss the connection between mental and physical conditions; discuss recovery, wellness and ways to building resilience.

The clinical mental health training also must address how congregations can be more inclusive of mental health, make referrals to a mental health professional or for mental health treatment; understand the differences between a religious and spiritual problem from a mental health illness; how to effective support someone suffering from a mental bealth situation.

Secondly, the research will show that if clergy and religious or spiritual leaders are effectively educated on the importance of mental health awareness for themselves then they will be more apt to support mental health in their congregations. Third, the research will show that many clergy are desiring more education and training on mental health in their congregations.

Methodology

The methodology for this project consists of qualitative research based upon action researcb, using qualitative tools. Pre-and post-tests were used to test the knowledge of the participants around their own knowledge and experience around mental health. The usage of a pre-test helped to gather what knowledge that the participant had regarding mental health and the post-test helped the researcher to discover any change in

knowledge after the clinical model project was implemented. Interviews and participant feedback gave the researcher a better understanding of the depth of learning gathered from the clinical project.

The focus group gathered in the personal interviews and a reflective review of the training process helped the research gather data from an individual and group prospective. This clinical model project used a focus group formed from the context for which this project was created. Qualitative research was chosen based upon Denzin and Lincoln definition of qualitative research and explained further in Swinton and Mowat's[2] research as being "…multi-method in focus, involving an interpretative, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them."[3]

In this project, one of the objectives was to gain a better understanding of why religious and spiritual people especially African-American congregations are so reluctant to embrace and understand mental health. Qualitative research in this setting allowed for the focus group members to feel comfortable in their natural setting. This setting needed to be non-threating and non-judgmental in nature.

The hypothesis of the project is: In following the mission of the church in providing pastoral care to the whole person, is a great need for clergy and the congregants to become culturally and competently educated and aware around the importance of

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[2] J. Swinton and H. Mowat, *Practical Theology and Qualitative Research* (London, UK: SCM Press Invicta House, 2013).

[3] N. K. Denzin and Y. S. Lincoln, *Collecting and Interpreting Qualitative Materials* (Thousand Oaks, CA: Sage, 2000).

mental health. First, clergy and congregation must address the stigmas and stereotypes associated with mental health. There is a tendency within congregations to ignore the signs of mental breakdown and trauma. The traditional model of mental health among clergy and congregation have been to blame the person experiencing a mental health challenge, isolate them from the rest of the congregation and neglect to address their spiritual need, provide effective pastoral care, and a therapeutic environment.

Secondly, clergy and congregations must acknowledge mental health as a part of one's spiritual and pastoral care responsibilities. Clergy and congregations must be educated about mental health to follow the mission and teaching of Jesus as caring for the sheep and the shepherd. Providing healthy places of spiritual wellness, emotional healing and wholeness is the mission and responsibility of the church.

Thirdly, clergy and congregations must be willing to seek professional help and clinical training from trained and licensed mental health professionals. The stigmas and stereotypes around mental health cause many congregations to reject any help or outside support from trained and licensed professionals.

This proposed clinical model will include training for developing multicultural competent religious leaders and congregations around their need for mental health services and a creation of a specific ministry model of ministry which incorporates spiritual and pastoral care for holistic development. The training and ministry model will connect to the biblical, historical, and theological interpretations as it incorporates the theoretical foundations in ministry practice, pastoral care and counseling, psychology and human development.

This method of study will utilize the methodology triangulation involving quantitative methods designed to increase participants' awareness of mental health and knowledge of their own mental and spiritual health. The participants will also learn the ability to utilize culturally relevant skills, techniques and interventions needed to address fully their mental health awareness concerns. Some examples of these concerns are:

- What are the participants' knowledge of mental health?
- What are the participants concerns about receiving mental health counselling in their church setting?
- Are they currently seeking or attend mental health counseling services?
- If they are seeking mental health services, are they attending through the church or an outside provider?
- Would they seek mental health services from leaders in the church?
- Do they see a connection between their spirituality and their mental health?

The quantitative data will in the form of a pre-and post-test survey that will be administered to the participants of the workshop. The workshop will include a basic pastoral care and counseling clinical training model for participants centered on the importance of providing competencies with the incorporation of their mental and their spiritual health.

Focus Group

The study group contained eight group members that represent the context for which this project is based upon. Some of the group members have former theological training and other group members are currently enrolled in some level of theological

education. The ages ranged from forty to sixty years of age. The focus group also consisted of all current clergy members or persons who have expressed a call to ministry. The faith background of the members of this group is Christian and many group member come from non-denominational settings. The group consists of two African-American (black) male and six African-American (black) females.

Clinical Model Project

The clinical model taught to the focus group was entitled, "Mental Health: A Guide for Faith Leaders."[4] This model consisted of two parts: Part One - Mental Health Overview and Part Two- Faith Leaders Support for People with Mental Illness. This model addressed information around, what is mental illness, common mental illnesses, suicide, diagnosis, mental health treatment, the connection between mental and physical conditions, and recovery, wellness and building resilience. Part Two addressed - how congregations can be more inclusive and welcoming, when to make a referral to a mental health professional, how to make a referral for mental health treatment, dealing with resistance to accepting mental health treatment, distinguishing religious or spiritual problems from mental illness and approaching a person with an urgent mental health concern.

This follow the overall goal of the project which will discover ways in which congregations and religious leaders can be more aware of mental health and therefore making it a part of their spiritual development within the church.

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[4] American Psychiatric Association., "Mental Health: A Guide for Faith Leaders," accessed December 15, 2016, www.psychiatry.org.

Implementation

Implementation One - Workshop Implementation

The Workshop fulfills as stated in the project proposal of developing a clinical model for helping with mental health awareness. The pre-and post- tests implemented to gain the core existing knowledge of mental health services and to examine the participant's own thoughts, attitudes and feelings around mental health in their churches and their communities.

Pre-Test Questions

The first two questions were gender and age questions, which resulted in the following:

The group was 75% African-American female and 25% African-American male. The group ages ranged from 75% ages thirty-five to fifty-four and 25% fifty-five to sixty-four years of age.

Question Three - In general, how would you rate your overall mental or emotional health?

Results - 25% Excellent; 50% Very Good; 12.5% Good and 12.5% Fair

Question Four - Have you ever received mental health services?

Results - 75% Yes; 25%No

Question Five - What is your definition of mental health?

Results - disorder that affects mood, thinking and behavior; assistance with your psychological and emotional being with a trained person; the ahility to move through emotional and psychological experiences in a positive way; the health of your mind and how to handle life's challenges and situations; services that assist in managing your

mental thoughts; feeling grounded in peace; health of the mind; unbalance in one's thinking.

Question Six - What are some common mental illnesses?

Results - mood changes, personality, habits, withdrawals; depression, anxiety, schizophrenia, addictive behaviors; depression, OCD, anxiety; depression, bipolar; depression and anxiety; bi-polar; anorexia, multi-personality; paranoid, schizophrenia

Question Seven - In your opinion, how important do you feel mental health is to your spiritual development?

Results- 87.5% extremely important;12.5% somewhat important

Question Eight - Do you feel you need more training in mental health?

Results- 100% YES

Question Nine - Do you feel that congregants are reluctant to receive services in mental health?

Results- 25% Yes 37.5 NO 37.5% Unsure

Question Ten - In your opinion, what are the stigmas or barriers that hinder persons from getting mental health services?

Reasons - stigmas; they do not want to be labeled or shunned; cultural; fear; lack of awareness; distrust of professionals.

Post Test Questions

Question One - How helpful was this workshop?

Results - 40% Extremely Helpful; 60% Very Helpful; 0% Not Helpful

Question Two - Do you feel like you need more training in mental health after this training?

Results - Yes 100%

Question Three- What did you learn from the workshop?

Results - Mental health training is needed more in society than ever; We need to be more aware of mental health conditions and how to be able to address mental health; I learned different topics that clarified mental health; Mental health needs to be addressed by pastors and other working with people; I learned to have empathy for people and what people are dealing with in life; be more aware and observant of other people's behavior.

Summary

The data suggest there is a lack of mental health awareness which leads to the church being ineffective in dealing with mental health and wellness. Secondly, there is more training need in addressing mental health for the church to be effective. The hypothesis of this project is: If clergy and congregations become culturally and competently educated and aware of their mental health then they can become more effective in helping, caring and serving others. The hypothesis was supported by the research. The more that clergy and congregations are more aware of mental health, the more effective the church can become in helping, serving and caring for themselves and others.

Implementation Two- Reflection Group

The Reflection Group was used as a tool for exploration after the workshop in a group setting. The reflection reflected around the need for mental health awareness and understanding in the local church. One participant felt that the congregations are ready

for mental health services but the leadership is not on board with the need for mental health services. Another participant stated that clergy and religious leaders need to understand the importance of their own mental health services, then they will be more willing to accept mental health services for the congregations. Another participant felt that many clergy need more training in mental health services and pastoral care. Another participant stated that the stigmas of mental health and lack of trust hinders many people in their religious community from getting help. Another stated that they were told that all they needed to do was to pray and trust God in the process and we do not need to get help for our mental health.

Summary

The data suggest that there is a greater need for clergy training in mental health. The data also suggest that stigmas play a major role in addressing the subject of mental health. Clergy, religious leaders and parishioners need to do more than just praying for people but must refer parishioners as well. Clergy must also seek mental health services themselves to maintain their own wellness. Ineffectiveness in understanding their own mental health causes an ineffectiveness in the functioning of mental health.

Implementation Three- Personal Interviews

The personal interview provided another analysis of observations of the current participants from the mental health clinical model training. The personal interviews provided two purposes for the methodology of the project. The purpose of this project is two-fold: it will explore reasons why the African-American congregations are ineffective and ignorant concerning many aspects of mental health based upon my theory.

The first goal of the personal interviews was to gather qualitative data to understand the impact of the clinical training on the participants. Secondly, the goal was to gain further insight into their own understanding of mental health. Third, the goal was to share their own personal experiences with mental health awareness.

Structured Interview Questions for Mental Health in African-American Church

Age:

Race/Ethnicity:

Denominational:

Educational Experience:

A) What are your thoughts around mental health in your religious or spiritual community?

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

C) What do you feel the responsibility and response of the church regarding mental health?

Results

Participant One

Age: Fifty

Race/Ethnicity: African-American Male

Denominational: Non-Denominational

Educational Experience: Bachelor

A) What are your thoughts around mental health in your religious or spiritual community?

Mental Health is not being addressed in the African-American community, therefore churches are not addressing the issue. There is a lot of hiding and ignoring the issue.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

Mental health challenges these religious beliefs especially in the African-American community. The confidentiality and trust are two stigmas that come to mind when dealing with receiving mental health services.

C) What do you feel the responsibility and response of the church regarding mental health?

It is the church's responsibility to address the issue and provide some referral system for mental health services.

Participant Two

Age: Fifty-Nine

Race/Ethnicity: African-American Male

Denominational: Non-denominational

Educational Experience: Bachelor

A) What are your thoughts around mental health in your religious or spiritual community?

I feel that many church don't think about mental health. I feel that a lot of people [think] that the connection with God is enough and you don't need any of assistance. People use religious statements to hide from dealing with mental health.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

When addressing mental health, people associate that with being crazy. This comes from a lack of understanding and ignorance. People don't know enough about mental health to understanding it. There is a lack of education and generaliz[ation] around mental health or the need for mental health.

C) What do you feel the responsibility and response of the church should be regarding mental health?

I feel that the church should understand the importance of mental health and devoting a part of their ministry to mental health. The mental awareness begins in the pulpit and with religious leadership.

Participant Three

Age: Forty-Six

Race/Ethnicity: African-American Female

Denominational: Non-denominational

Educational Experience: Masters

A) What are your thoughts around mental health in your religious or spiritual community?

Mental health is very misunderstood by many people in my community. There is lack of knowledge around mental health in my community.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

The stigmas of mental health are what keeps many persons in the community from receiving services like being labeled "crazy," disassociated from family, lack of trust of mental health professionals and access to effective mental health services.

C) What do you feel the responsibility and response of the church regarding mental health?

The responsibility of the church is to provide education around mental health services for its congregants. The more people understand mental health, the more they will be more open to receive mental health services.

Participant Four

Age: Forty-Six

Race/Ethnicity: African-American Female

Denominational: Non-denominational

Educational Experience: Bachelors

A) What are your thoughts around mental health in your religious or spiritual community?

Mental health is not discussed in good terms in my community. If it is discussed, it is discussed in negative terms of being crazy or something is wrong with the person.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

The stigmas that are associated with mental health is that something is wrong or abnormal. It is never discussed in spiritual terms or God. There seems to be a lack of awareness for mental health or anything dealing with the mind. There was never any encouragement to seek mental health services or seek help away from the church. I only heard that you are to pray those things away.

C) What do you feel the responsihility and response of the church regarding mental health?

I feel that the church is ready for understanding mental health however the issue is the pastors and church leadership not understanding the importance and benefits of mental health.

Participant Five

Age: Forty-Eight

Race/Ethnicity: African- American Female

Denominational: Non-denominational

Educational Experience: High School

A) What are your thoughts around mental health in your religious or spiritual community?

I feel that mental health is an area that needs to be explored within the religious institution and the society.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

I feel that the stigmas of people don't want to deal with the community instead of running away or hiding their issues. We need to examine the way we do the ministry of mental health to demonstrate healthy minds and healthy lives.

C) What do you feel the responsibility and response of the church regarding mental health?

The responsibility is to serve the needs of the congregation and community. Everything flows from the mental health. The church will never [be] effective unless we support mental health.

Participant Six

Age: Sixty

Race/Ethnicity: African-American Female

Denominational: Non-denominational

Educational Experience: High School Diploma/ Biblical Training (Non- seminary)

A) What are your thoughts around mental health in your religious or spiritual community?

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

C) What do you feel the responsibility and response of the church regarding mental health?

Participant Seven

Age: Forty

Race/Ethnicity: African- American Female

Denominational: Non-denominational

Educational Experience: Masters

A) What are your thoughts around mental health in your religious or spiritual community?

I feel that we need to refer all mental health counseling services to trained and licensed mental health professionals. I feel that the churches are not equipped with licensed professionals to deal with the level and aspect of mental health illness that many people are dealing and suffering with.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

The stigmas of mental health [in] our community is from moving forth in helping persons with mental health challenges. The stigmas need to be addressed to help normalize getting mental health services.

C) What do you feel the responsibility and response of the church regarding mental health?

The church has a responsibility to be educated in areas of mental health and to refer to services. I feel that the church should be a referral service to professional services and not provide these services within the church.

Participant Eight

Age: Thirty-Five

Race/Ethnicity: African-American female

Denominational: Non-denominational

Educational Experience: Master's

A) What are your thoughts around mental health in your religious or spiritual community?

I believe that mental health is a part of one's spiritual growth. We need to continue to have conversations around mental health as a part of one's overall health.

B) What are the stigmas associated with mental health around mental health in your spiritual or religious community?

The stigmas associated with mental health damages communities because it stops people from receiving services.

C) What do you feel the responsibility and response of the church regarding mental health?

The church should be on the frontline in providing the spiritual and mental health needs of its spiritual community. The church should provide psychoeducational support around mental health services which will promote mental health services.

Summary

The data suggest that mental health will have to be viewed as a part of one's spiritual and emotional development for the church to understand the importance of mental health. Secondly, it shows that for many people, it is the responsibility of the

church to provide some basic aspect of pastoral care in addressing mental health and creating an effective and efficient system to mental health on a basic level. The data suggests that the more that the church becomes aware of the benefits psychological and spiritually, the more that the church can support and become an agent for change in furthering the stigmas of mental health.

Summary of Learning

The project did fulfill the overall goal of the project. The overall project goals were:

1) To explore the importance of mental health awareness in African-American congregations.

2) To establish the importance of mental health awareness as part of a person's spiritual identity and development.

3) To discover the reasons why congregations do not seek professional mental health services within the congregations and the community.

4) To establish a clinical model to address mental health effectively within congregations.

This project shows how important mental health awareness is in the African-American congregations. The implementation of the workshop showed that education around mental health is greatly needed in the African-American context.

Learning from the Project

A) The project also showed from a biblical, historical, theoretical and theological perspective that mental health is part of one's spiritual identity and development.

B) The project did address reasons why clergy and congregations do not receive mental health services within the congregations and the community.

C) The project did develop a clinical model for addressing mental health effectively within congregations.

The hypothesis is that if clergy and congregations become culturally and competently educated and aware of their mental health then they can become more effective in helping, caring and serving others. The project shows that if clergy and congregations become more culturally and competently aware and educated of their own mental health then they can become more effective in helping, caring and serving others.

This project has created many opportunities to partner with churches such as Hillside International Truth Center and many other spiritual and community's agencies as my current practice being a referral source for providing affordable mental health services, training clergy and providing educational workshop for mental health services. This partnership with the local church has provided a prime example that churches can be provided effective referral and education services within the religious context.

The project has provided opportunities for discussion in religious communities. This project has enabled me to conduct several Shattering the Stigma of Mental Health Workshops and participant in several mental health panels in the community.

Project Reflections

In reflecting on the ministry project there are several things that would have worked out differently. The first change would have been a study of the counseling and referral services at Hillside International Truth Center. This information would have been very helpful in creating effective partnerships with church regarding mental health services.

Secondly, the ministry project would have used the congregants in examining the effects of the clinical model for mental health on the congregants. Examining more congregant's attitudes and feelings around mental health can provide effective support.

Third, the ministry project could have heen more enhanced with a series of sermons around mental health and spirituality. Sermons around mental health can provide spiritual growth as well as psychoeducational opportunities. Sermons and teachings can also start effective conversations around mental health. Healthy conversations around mental illness can be very helpful in combating the stigmas in mental health in the church.

Fourth, the ministry project could have enhanced with a group of clergy person's understanding their own mental health issues. The project has shown that clergy must be in touch with their own mental health issues to support others in receiving effective mental health services. Clergy are frontline responders in helping their community and congregations in normalizing mental health services.

New Integration Toward a Theology of Mental Health

This ministry project has birthed a new understanding of the need for the integration of mental health and spirituality. This ministry project has also showed that there is a great need for more persons interested in the work of mental health theology. This theology of mental health that incorporates an intergradation of further examination of the mind, body and Spirit and how it impacts our spiritual and psychological functioning.

Spirituality deals with all human life from a religious, psychological, mental, emotional aspect. The goal is that the African-American church must become holistic and healthy in its approacb to living out God's work of voicing the Gospel and Good News.

Effective Partnerships for Mental Health

This project has expanded my understanding of how mental health can be effective and work within the walls of the church and the African-American community. Developing effective partnerships that will be great benefits to the church as well the community agencies are important. Mental health agencies can be very beneficial in providing mental health training. However, confidentiality and proper consent is a critical aspect of professional mental health services. Understanding the role of establishing effective boundaries, the aspects of confidentiality, dual relationships and the proper client consent are vital in providing proper mental health services.

This ministry project helped to form and preach a sermon entitled, "The Power of a Transformed Mind" (Roms 12:1-2) which focuses on the shift burnt offering sacrifices to God from spiritual worship. Worship requires our bodies and our minds to please God.

This sacrifice of the body and mind helps us to then discern what the will of God is for us.

This project has helped me to create a radio show entitled, "Therapeutic Conversations: Having Conversations Around Mental Health, Spirituality and Empowerment." This platform uses social media to raise people's awareness about the importance of mental health and wellness within spiritual communities.

Further Considerations

A) Effective, Professional and Trained Mental Health Services

The mental health providers must be trained in understanding the spiritual aspects of the individuals that they serve. There are confidentiality and other risk factors that should be considered. Trained and professional mental health understands the confidentiality, the client's consent to treatment and the risk factors such as mandating reporting of abuse.

B) Affordable and Accessible Mental Services

Mental health brings many fears and misunderstandings around treatment and diagnosis. Mental health professionals can provide psychoeducational information that can be helpful in successful treatment. Churches can be effective places in providing psychoeducational information for their church. Congregants can provide safe places for people to ask questions around mental health and effective treatment.

Congregants have the right to affordable and accessible mental health services. Churches can play an effective role in referring congregants to mental health services. Churches can also be effective in providing basic clinical services with the proper

training under the aspects of pastoral care. Successful pastoral care training and services can be effective in helping congregants work through their mental health challenges and provide effective referral services.

C) Financial considerations for the support of mental health services.

If the African-American church must understand that it takes financial support to help further the work of mental health awareness, education and effective services. There are funding and financial considerations for providing effective mental health services within the walls of the church. Many churches cover the first few counseling services if their church does not provide the direct services. Many churches have moved toward having a trained and licensed staff member which provides the direct mental health services and provide the psychoeducational services for the congregations.

The more African-Americans are educated, there seems to be less influence of the African American minister or pastor. African American leadership especially pastors need to be trained and educated to be helpful and effective in helping the congregants. This transformation requires more education and skill for the African- American clergy. Wimberly suggests that the clergy develop new skills to help African American clergy be more relevant and influential in the church and the community. Wimberly states:

> Slowly, black people have begun to look away from the church for leadership, because more and more black people are being educated and trained opportunities for black lay people outside the church have been lessening the influence of the black preacher. As a result of this new development, many pastors are in the midst of an identity crisis and need help in developing new skills of guiding.[5]

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[5] Edward Wimberly, *Pastoral Care in the Black Church* (Nashville, TN: Abington Press, 1979), 37.

These skills of guiding involve learning more about mental health and also developing clinical skills to be more effective in leading the twenty first century African American congregations.

African American clergy and leadership must educate their congregations on the value of mental health services and the cost of quality and professional services. Many congregants feel that they did not have to pay for the mental health services in the church. However, congregants must be educated on the importance of mental health services and the importance of financial support in providing effective and competent services.

D) Effective pastoral care training and a creation of a mental health network.

Tbere should be a consideration of a creation of an effective network that understands the specific needs and context of the African-American church. This mental network must understand the spiritual and psychological needs of the African-American church. Effective training in theology and psychology can be helpful in working with African-American congregations in mental health. "Spiritual transformation can be defined as dramatic changes in world and self-view, purposes, religious beliefs, attitudes, and behavior."[6] Understanding the integration between the spiritual and the psychological aspect of human life can be effective in helping congregants in the transformation process.

Richardson suggests that we must examine and address the professional identity and role of the African American minister as it relates to mental health. If African American leaders are comfort and clear around issues of mental health themselves, then

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[6] C. Stawski, "Definitions and Hypothesis: William James, Religion and Spiritual transformation," *Cross Currents* 53, no. 3 (2003): 425.

they are more apt to refer others to trained and licensed mental health professionals. Richardson states:

> Any discussion of the implication of this study for pastoral care needs to begin with an analysis of the black minister's so-called sense of "professional identity." For if the minister is not secure in his or her role and is in fact experiencing a crisis of identity precipitated by competition from mental health professionals, then the possibility strongly exists that their pastoral care effectiveness will be hampered. This is clearly evident in the pastoral care function of referral. When and if the need arises, a minister who is experiencing a "crisis of identity" will be resistant to referring a parishioner to a mental health professional for treatment.[7]

Conclusion

The African-American church is dire need of understanding the importance of mental health services. Bentz and Edgerton suggest that this transformation starts with the transformation of leaders and the impact negatively and positivity on mental health outcomes. Bentz and Edgerton suggest:

> The leadership of a community may be a major factor in changing attitudes toward mental illness. Leaders, by virtue of their positions, exert a tremendous influence on social norms, and should be considered as playing an important part in the process of attitude formation and change. The general public tends to follow social standards established and articulated by the community's leaders. Thus leaders, through their innovations and examples, can and do influence the attitudes of the general public toward mental illness.[8]

A theology of mental health is seen through the next biblical account as God is working with the spiritual, emotional and the psychological aspects of human life. There is such a great need for an integration of mental health and spirituality within the African-American church. This project shows that mental health awareness and mental health

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[7] Bernard Richardson, "Attitudes of Black Clergy Toward Mental Health Professionals: Implications for Pastoral Care," *Journal of Pastoral Care* 43, no. 1 (Spring 1989): 38.

[8] W. K. Bentz and J. W. Edgerton, "Consensus on Attitudes Toward Mental Illness Between Leaders and the General Public in a Rural Community," *Archives of General Psychiatry* 22 (1970): 468.

services is an enhancement and a blessing to any church's spiritual development. If humans are all made of mind, body and Spirit (Soul), therefore the mind is important part of our existence. It is the church's responsibility therefore to support the mental health of its congregations and clergy through partnerships, education and some churches providing mental health services.

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